April, 1959

MENTAL HYGIENE

Published Quarterly by the
National Association for Mental Health

Quarterly Journal of the

National Association for Mental Health, Inc.

GEORGE S. STEVENSON, M.D., *Editor*
Harriett Scantland Hoptner, *Assistant Editor*

MENTAL HYGIENE

MENTAL HYGIENE aims to bring dependable information to everyone interested in mental problems. Here are original papers by writers of authority, reviews of important books, reports of surveys, special investigations and new methods of prevention and treatment in the broad field of mental hygiene and psychopathology. Our aim is to make MENTAL HYGIENE indispensable to all thoughtful readers. Physicians, lawyers, educators, clergymen, public officials and students of social problems find it of special value.

$6.00 a year (Canadian $6.25; foreign $6.50). Single copy $1.50. Publication office: 49 Sheridan Ave., Albany 10, N. Y. Editorial and business office: 10 Columbus Circle, New York 19, N. Y. *Second class postage* paid at Albany, N. Y.

VOLUME FORTY-THREE, NUMBER TWO *April, 1959*

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HENRY V. DICKS, M.A., M.D., F.R.C.P.

Mental health in the light of ancient wisdom

We have to see that the Spirit must lean on Science as its guide in the world of reality, and that Science must turn to the Spirit for the meaning of Life.—CAREY BAYNES.

The trustees of the Mary Hemingway Rees Memorial have selected me for a signal honour—that of inaugurating a biennial succession of lectures devoted to the theme of mental health and spiritual values.

The gracious lady whose memory we—her many friends in the Federation—are thus perpetuating was herself the living witness to the harmonious blending of modern psychology and the religious faith of her fathers. At the corner of the street in which I live in London stands a solid granite church built by the piety and endeavor of Mary Hemingway's Scottish father, a church to serve the indomitable soul of her race as a rallying point in their diaspora in the far south of our island. Near the heart of London stands the Tavistock Clinic whose founding young Dr. Mary Hemingway perceived as a challenge, as one of the original technical bases in our country of the new impulse towards mental health. She became a staff member from the inception of that clinic in 1920. It was here that she met a certain Dr. John Rawlings Rees, with consequences which all of us in the mental health field have reason to be grateful for.

If I have a qualification for this memorial lectureship, it is my long association and the privilege of friendship with Mary and Jack Rees, cemented by the common joy in the building up of the Tavistock Clinic. It is not easy to resist the impulse towards personal tribute to a great-hearted, charitable and serene woman from whom one has received numberless kindnesses, whose devotion to the ideals of her chosen vocation of

Dr. Dicks, consultant psychiatrist of the Tavistock Clinic, London, presented this paper—the first Mary Hemingway Rees Memorial Lecture—before the 11th annual meeting of the World Federation for Mental Health in Vienna in August 1958.

medical psychotherapy one has closely experienced and of whose person one has been a warm admirer. Yet it is a more fitting, if more difficult, task to carry praise and remembrance to the point where our gratitude becomes transformed into learning, where the vanished relationship is internalized as enhanced understanding and our loss made good by the strength gained through our assimilation of the lessons of such a life as Molly Rees's.

I think it important at the outset of the first of a series of lectures, which will go on in perpetuity, to state the reasons why the founders of the World Federation for Mental Health, who knew her personally, felt it appropriate to commemorate her life and influence in this manner. In this way I hope to generalize and hand on the precious lesson to our successors and to friends in many lands, and perhaps sound the keynote on which successive future lectures will be variations and elaborations. The reason, surely, is the impressive demonstration to us, her contemporaries, of the strength and fruitfulness of personal and interpersonal integration in the service of shared spiritual values exemplified in the lives of our founding president and now director, Dr. J. R. Rees, and his late wife.

Now I am already deep into the main theme of my discourse. Can we doubt that a man whose role is instrumental, ordering and creating is sustained by the woman who is expressive, nourishing and cherishing? Was there ever a man who could bring forth change and new life in love of mankind that was not nourished from the undemanding, giving sources of his chosen woman, who thus affirmed and reflected his values, gave him strength and renewal, and sanctioned his mind's visions by her feelings? This is one level at which mental health fulfils both partners in a meaningful relationship. To borrow from one of the oldest of wisdoms—this is the *Yang* and the *Yin* in operation in the married pair.

At another level, we have seen Mary Hemingway Rees integrating in her own person the physician and the wife and mother under the primacy of values derived from her strong Christian faith. In her youth this meant a very considerable achievement in fearlessness and autonomy. Not only for a girl to study medicine at all—but also after that to rebel against medical orthodoxy and enter the still suspect if not downright indecent field of analytic psychotherapy, at that time perceived as strongly subversive of moral values. Not only to gain success in this vocation but then to blend it with the feminine destiny of wife and mother, and emerge in the face of handicapping physical suffering as the wise, tranquil and gracious personality whose self-effacing sympathy and goodness many of us here assembled have been privileged to see in action. We all know what can and does happen under such possibilities of role conflict and of pressure from somatic factors, and so we are gratefully renewed in our faith in human resources when we see the precarious experiment succeed so well in a human being.

Here, then, is our subject exemplified in a remarkable personality. Mary Rees has set us speculating on a theme which is at the very core of the search for mental health. In wondering what was the secret of her personal integration and maturity, we are posing the problem she solved so gracefully by living it out. I should like to spell out some of the research questions we may hope to see answered in these memorial lectures which arise in my mind as the result of contemplating Mary Hemingway Rees's life and personality.

These are some of the questions one would wish answered as the memorial lectures unfold in the succession of years:

- What is the part played by spiritual values in the integration and maturation of the individual person and of human groups, notably the family group? And under what circumstances may spiritual values function in the direction of mental health for individuals and groups, and under what circumstances may they, if ever, hinder it?

- What must happen inside individuals to make this potentially powerful force active for the purposes of mental health and good human relations?

- Can systems older than modern behavioural science provide any guide to us who are endeavouring to bring about better mental and social health as to how *they* tried to solve this problem, and so set our modern principles and practice in historical perspective?

These are only a few of the possible basic questions. But even in these there is a challenge for any number of lectures and research projects. These could, for example, include statistical comparison of the incidence of every form of psycho-social disturbance in individuals and groups holding or not holding various types and intensities of spiritual values; spiritual healing; religious elements in transference phenomena; the nature of creative culture myths and beliefs; methodology of the study of religious and other value systems in individuals and groups, and so on.

You will note that in these questions and lists I have not even included the metaphysical problems of the reality or otherwise of the sources of such values, perhaps because in one's training in natural science one has been taught that this problem lies outside the scientific realm. This in itself is already a value judgment, one with the slightly dated flavour of scientism—a vogue or fashion of the *Zeitgeist* which has us preoccupied with control of the "how" of phenomena and tends to ignore the "why" and the "whither."

By contrast with this bleak "scientism" of our day it would seem most worth while to start our series by looking at some old teaching about the nature of man and his relation to his own being and to the macrocosm, which stands diametrically opposed to our Western science. I refer to the religious philosophies which have for over two and a half thousand years inspired two of the greatest civilizations—India and China—and shed their light into their neighbours' lands. I shall hope to show that, behind many differences, they have in common this concentration on a science and practice by which man is expected to become a fully developed, integrated person aware of being at one with the universal source of life and Being and freed from crippling partial loyalties. To those great religions Being and Becoming of men mattered supremely, social organization and action hardly at all. Theirs was an age of one kind of behavioural science—control of man's evolution from within himself.

I conceive that by beginning our series of memorial lectures with a glance at these ancient and still not widely understood systems we are not only paying our respect to venerable and profound doctrines concerned with our problem. We are also serving the purposes of a world federation to whom the great achievements and the future of every part of its universal membership is equally precious. And we are looking perhaps at our own ancient forerunners —namely, psychological systems meant to make men happy, free and good. Let me

hasten to add that I claim no more than a superficial acquaintance with my theme and acknowledge a profound indebtedness to those scholars on whose work I have freely drawn for my task.[1]

VALUES IN MENTAL HEALTH ACTION

The institution of these lectures on mental health and spiritual values is timely. As I stated in 1950, there is, in wide circles of our movement and our professions, almost a taboo on this subject. At our congresses the subject may be mentioned, a discussion group may be set up (and I believe Mary Hemingway Rees was largely responsible for such an innovation), but it is only very lately and rather drily that some social scientists have begun to examine the significance of values for the behaviour of individuals and groups. And these values are usually taken in a retrospective sense from the culture pattern from which an individual or a population under study has emerged, rarely from the more profound point of view of anagogic goals.

Yet it would be a piece of gross dissociation for any of us to pretend that we are neutral, desiccated scientists for whom all ideas are equal! At least we all have in our minds that mental health itself is a value—or we would not devote our lives and our energies to it. Everybody has some intellectual definition of mental health but few could give their full, inspirational sources—yes, their fantasy!—of the goal towards which they are working in pursuing their therapeutic or other mental health activities. I will say at once that I believe the values we hold are indeed very close to those which the major Eastern religious philosophies have always represented as their central tenets. In these great oriental systems of thought and practice there was a foreshadowing of a faith in the possible unfoldment of humanity, which we here, and the circles who pursue the scientific study of mental health, are translating slowly into a possibility of mundane, concrete fulfilment. By way of analogy, ancient Democritus formulated an atomic theory, as part of a world picture, but it was left to scientists 2,000 years later to implement this by empirical research, and not only prove it but also apply it to the material universe and make atomic energy available for common use—good and evil.

So we, also, do what is an unprecedented new thing in the world: we try to promote and enhance human maturity and self-mastery on the basis of rationally intelligible concepts won in the empirical way by the exercise of technical skills. But the outline and the stock of ideas have been there through long ages. Even the most dilettante reading of such works as the *Bhagavad-Gita* and the Buddha's *Dhammapada* from India, or of the books on Taiosm and on that most unique flower of Chinese Buddhist synthesis with Taoism, Zen, show how clearly these ancient masters saw the problems of what we would now call the unconscious and its relation to the total personality, and their developed techniques for making its treasures available in a balanced gracious life.

What we work towards—the goal value of mental health—is comparable to the old religious aspirations of "finding God," of "salvation," "liberation" and "perfection," ideas which have moved men in all eras of history. At the more social level we have the vision of the "good society" or the "kingdom of God," perhaps more typical of Western humanity. Even those of us who may be inclined to stress the social or

[1] Notably the writings of Alan Watts, Dr. D. T. Suzuki, Shri Krishna Prem and Christmas Humphreys.

group aspect of mental health will scarcely deny that the ultimate reason for bringing about a peaceable, prosperous and enlightened world community is the provision of a milieu in which the human personality can enjoy full flowering, neither too individualistic nor yet a mere "number" in a kind of perfectly run human beehive. We want men to be happy, good and free. So did Gautama the Buddha, and Lao-Tsu.

Among the goal-values which are commonly held by the mental health professions, especially those concerned with therapy, I want to consider the chief three: the concept of adjustment, the concept of self-realization and the concept of integration of the personality. On each of these the ancient Eastern teachings have had volumes to say and thousands of years of practical experience in their pupil and teacher systems, which has produced human greatness in its most exalted forms, equalling and perhaps at its best even surpassing the mental giants of the Graeco-Judaeo-Christian world.

ADJUSTMENT

First, then, let us look at adjustment as a goal for men, as a target for the mental health worker—for himself and his clients. The stress in this concept is on man's reconciling himself to his society, on society as the centre and frame of reference. Adjustment can mean that somebody who is in revolt against his society should be brought to conformity with the norms, sometimes the therapist's own. Such a notion would make of mental health itself a norm, an average fitting into the current culture pattern and the local social values. Totalitarian institutions require that complete control over deviant thoughts and feelings: for example, the monotonous ideal of the new type of Soviet man reiterated in contemporary Russian literature or the stereotyped criteria we had to apply when, during the second war, we selected a variety of civilian men for suitability as officers. Again, the best "adjusters" to Nazi norms were not, as we now know, the most mentally healthy.

Charles Morris, the American philosopher, studied the preferences for different patterns of living and gaining fulfilment of various personality types. These patterns, even within one national culture, show a much greater divergence than that which our Western society regards as "normal." He concludes that the so-called "norm" cannot answer to the varieties of personality needs. He wrote: "A society adequate to contemporary men must be pluralistic enough to permit diversified lives appropriate to the diversity of its members. It must be zealous in the protection of those psychological minorities which we now disregard and maim. . . . It must have a new ideal of selfhood, shared by enough persons to furnish the unity without which diversity becomes chaos." In the *Gita,* the Lord Krishna says: "Howsoever men approach me, even so do I welcome them, for the path men take from every side is mine."

The first sample (and I can offer only samples) of Eastern wisdom concerns precisely this basic issue: a "new ideal of selfhood shared by enough persons to furnish a unity" without which there would be anomie, anarchy, chaos. For let us not forget that there is not only persistence but also loss of the old unities: of local identifications enforced by authoritarian rule, of external religious and social sanctions buttressing patriarchy and clan solidarity and conformity. These are being swept away by secularization and technical revolution. Modern man is both in revolt against these old authority systems and unhappy without them, not knowing by what light to live. Adjustment of the individual to norms was

appropriate for a period when conformity to stable, generally accepted values was a condition of survival. Men still crave for restoration of authority over them, and are easily led back to subjection. This invites the power-holder, be he priest, politician or psychiatrist, to exercise his power over his flock, to coerce, cajole or persuade them—and especially the deviants—to the prevalent pattern.

This is the injury done to individuals even though they ask for it. Whether done in the name of religious dogma, or political ideology, or therapeutic norm, this concept of adjustment always contrasts a "we" who know what is best with a "they" who are in sin or in error or in sickness. It is an expression of dualism, of the existence of opposites, with the subject in the good position and the other in the bad position. Forms of coercion are invented to make people obey the Sermon on the Mount or the rules of Confucius. Children discover good and evil by reference to rewards, prohibitions and punishments. From the preambivalent unity of the infant we enter ambivalence and the conflict of opposites.

It is from this painful and conflictful dilemma of coping with this ambivalence, with the struggle between love and hate, submission and rebellion, that the great teachings of the Indian Vedanta offer deliverance: the *Bhagavad-Gita* is one of the purest condensations of them, and the doctrine of Gautama the Buddha, himself born an Indian, is built on them. How different from conformity is the call in the *Gita* and in the *Dhammapada* to forsake idolatry, to develop the self and put one's faith in one's own destiny. It is an assertion of the possibility of every man to know his inner self and to find that it is one with the divine nature. "He who seeth Me everywhere, and seeth everything in Me, of him will I never lose hold, and he shall never lose hold of Me." (*Gita,* sixth discourse.) Again: "Look within, for Thou art Buddha." "Work out your own salvation with diligence." "Each man his own helper, each his own host."

What becomes of the goal value of man's adjustment to his environment at the hands of such teachings will be taken up later. First we must look at our other two postulated modern mental health values: self-realization and integration.

SELF-REALIZATION

This concept, often heard from the mouths of persons in mental health work, has for me a meaning opposite to that of "adjustment." It is akin to "individuation" or "personal liberation." It carries many overtones which one connects with the aims of psychoanalysis: to free the flow of man's energies from the obstacles of infantile or culturally-induced fixations, to help him find his identity and make him unafraid to affirm it. In the process he will experience a sense of falling away of shutters or confining anxieties and, so to speak, wake up from his nightmares. All religious or spiritual teachings have had much to say on this subject, and they, as well as our own experiences in analytic work, have made us cautious of the dangers inherent in this aspiration. It can be another form of "self"—opposition to the "other," to the external environment, a false or spurious self-liberation, inflating *hybris* or self-centred pride in defiance of others and of the values of society. It is a narcissistic aim which reminds us of those people, whether in religious life or in our consulting rooms, who hunt after personal salvation, omnipotence and freedom from social constraint—*the sacro egoismo*—and believe that they will find health and happiness that way. If the search for "adjustment to norms" is a concept of ascetic giving up of too much self-

will, then "self-realization" is its opposite—the escape from the pain of group responsibility and self-limitation.

The traditions and words of the ancient masters were unanimous in unmasking the self-inflation hidden in such striving, just as the modern analyst will become aware of the deep hate contained in the imperious wish of his patient to share the secrets of power and happiness he believes the therapist to possess. It was a misunderstanding alike of the aims of *yoga* of old and of analysis of our day to accuse them of working to bring this about.

It has often been mistakenly assumed and stated that the great Indian and Chinese religious systems advocate precisely this achievement of a self-centred, world-denying condition, that they have turned the individual away from facing his worldly responsibility, that, in other words, they are guilty of the very error we have just spoken of—of forsaking and despising the world. Reading about them, one can see how this has come about, just as a perusal of the works of Christian mystics and quietists might lead to similar conclusions about the central tenets of the Western faith. Though the impressions left on many Western readers by the writings of Indian and Chinese sages seem to be directed at achievement of self-realization in the bleak, salvation-seeking manner I have indicated and letting the world go hang, in fact they are essentially concerned with something other than this—something close to our third goal value for mental health.

INTEGRATION

Integration is a concept capable of reconciling the two goals of adjustment (to the society and its shortcomings) and self-realization. I have elsewhere proposed a definition of integration as "an event in the personality resulting in the pooling or synergism of its energy resources hitherto polarized so as to neutralize each other." This involves something of the Hegelian idea of synthesis from thesis and antithesis; of the idea of the person as a total self, emerging from resolution of conflict; not the little self which Freud called the ego with its defenses and rationalizations, nor yet some deeply hidden virtue residing in the "unconscious" unilaterally released—but in the harmonious interaction of both systems as one, in the form and life of the whole. In this matter modern dynamic psychology seems in much closer agreement with the Advaita doctrine of Vedanta, with Buddha's doctrine of the Middle Way and with the concept of the Tao in Lao-Tsu's teaching than with Christianity (unless the latter is read in a very mystical, rather unorthodox way). Advaita means "not two." The world of form and the world of the spirit are the same. It is true that at one extreme this doctrine degenerates into spiritual monism and nihilism—"nothing is real except the Absolute" . . . "all forms are illusion." But against this is the wonderful passage: "In darkness are they who worship the world alone, but in greater darkness they who worship the Infinite alone." The infinite has no meaning apart from its opposite—the finite. Its meaning is that these two are one, and that one is the whole—Brahma. The world of form ceases to be illusory when the many become the One. Light is, when energy meets resistance—as witness the current and the filament of the electric lamp. Vedantist and Buddhist alike hold that "the formed and the formless are one; the mortal and immortal, the definite and the indefinite." Buddha's principle of the Middle Way lies in the understanding and implementation of this unity in opposition. The Tao, also, is the unifying principle behind the *Yang* or masculine and the *Yin* or feminine,

whose union in interaction is life, constantly changing and elusive.

We in the West have so far not got far beyond thinking in antinomies. Even in our modern psychology we have tended to take our various patterns of this dualism without resolution of the conflict. When speaking of man—the microcosm—it makes little difference whether we call the opposites love and hate, good and evil, or God and Satan. There is much in common between these, and with Freud's early formulation of the "good conscious ego" and the primitive "anarchic" id. We still quarrel over the reality of mind as against matter as the only reality. This has a very real bearing on our whole approach to human conflict.

The former position is rare in Western medical philosophy, but it finds expression in Christian Science. The latter position —"the darkness of those who worship the world alone"—is that of scientific mechanism, which leads to a logical cul-de-sac, namely, the futility of its own formulations as meaningless "epiphenomena" of mechanical cerebration. Mechanical therapy can be its only result in medicine, while in the wider sense it leads to the Franckensteinian madness of coercing nature and less powerful human beings.

At a certain level, then, the ancient wisdom of the East had already foreshadowed our growing insight into the human problem of projecting onto the world picture the state of its own growth and maturation, which runs from non-differentiated potential through polarization or differentiation back into consciously realized fusion or reconciliation of the opposites—from preambivalence through conflict into integrated person, in modern terminology. The dualism which characterizes Western man's view of the mind:body problem (or, at cosmic level, the God:perceivable universe problem) can be held to be an index of the state of our psychological evolution. The Eastern wisdom can accept my statement in this form without a wince. Western religions have had trouble over Darwin until quite recently. The Eastern position is based on the idea of a single underlying Reality behind a multitude of forms issuing forth from it, differentiating themselves through aeons of time (quite *a la* Darwin) and seeking to return. This Reality is Aldous Huxley's Divine Ground. The illusion is that we are ever separate from it, that there is opposition between us and the Ground, that life is polarized into mind and matter—and the reality is their inseparable unity which is the spirit or life, flowing on, endlessly.

The effort, therefore, of the Eastern religious systems is to heal this illusion of separateness, the inner ambivalence, to bring about that event in energy resources and which they would call something like enlightment or finding the spirit. If human development is as we have reason to think it is, then ambivalence was and is as great a source of emotional pain in the East as it is in the West. Only the Eastern philosopher's concept of its fundamental cause or ethical base is rather different from ours. Their philosophy does not oppose God and man or God and the universe. (This *is* the great error or illusion for them.) They are seemingly polarized for the sake of the development of self-realization and differentiation of the human spirit. The achievement, the finding of the self, is contained in the discovery that this differentiation was, as it were, part of the Infinite finding itself again in full awareness in a myriad minds.

The act of creation is stated thus in the words of Brahma: "Having put forth a portion of myself, I remain." In another passage, we read: "Know My other nature . . . the life-element, . . . by which the universe

is upheld. Know this to be the womb of all beings. I am the source of the forthgoing of the whole universe and likewise the place of its dissolving . . . I the rapidity in waters . . . I the radiance in moon and sun . . . sound in ether, and virility in men; the pure fragrance of earths and the brilliance in fire am I; the life in all beings am I . . . Know me as the eternal seed of all beings. . . ." (*Bhagavad-Gita.*) Enlightenment is the coming to rest at the hub of the revolving wheel of life, is finding the centre.

ACHIEVEMENT OF INTEGRATION

It is not easy to convey the quintessential spirit of what the Vedantist, Buddhist and Taoist teachers advocated to the man who sought wisdom and liberation from oppressive inner conflict in some secure resting place of the soul, much as a patient might consult us today, and to convey it honestly, not overpainting the similarities or minimizing the differences. To begin with, let us not be put off by the fact that the instructions in numerous books and texts of 2,000 years ago are cast in religious terms, when all science and the world image were subsumed in these, or that they take for granted the reality of reincarnation, of the aeons of evolution before a given soul, risen through prehuman form and many rebirths to the point where it is searching for its liberation, asks "How shall I be saved, escaping the pain of lonely world existence?"

In very broad outline, the answer is not, as many Westerners as well as many of their own believers think, "Flee the evil world, mortify the body, sink yourself in a trance, and contemplate the Eternal." So far as one can tell, certain disciplines and exercises were prescribed much as an aspiring musician must do scales and arpeggios or an analysand must practice free association and observe his dreams. The excesses of *yoga,* of wild self-mortifying fakirs daubed with ash were as the excesses of Christian fanatics and anchorites in early monasticism. The answer was rather something which Gautama Buddha termed "The Middle Way," and which in China was known as the Tao.

Re-reading some of the essential literature again, one is surprised at the likeness to the aims and interpretations in present-day analytic therapy. The teachers and masters who knew what they had achieved and what they were talking about were at pains to get suitable individuals to see that the things of this world or about themselves were only disgusting or evil by what they called "attachment" to them, but in reality all were manifestations of the one divine self. All things were informed of this one life. A man had only to break through the barrier of his clinging to infantile self-gratifications and of the inevitable guilt that went with it to realize his own union, to reconcile his little ego and the universe (including his own nature) in a new integrate, to gain a vantage point at the root of the pendulum so that its swings from one side to the other, from self to non-self, were no longer beyond his cognizance and control. In this way man, instead of standing against the world in rebellion or in awe of external gods and demons of his own invention, learns that these are part of him, just as he is part of the world, that his reason—his ego—and his natural needs can be on the same side, living life.

To us this is part of developmental theory. The infant cannot yet distinguish body from ego, and projects and introjects the world freely in fantasy. Moral development, mental maturation, consists not only in separating these opposites, in knowing what is inside and what is outside, but also in gaining insight into the differences be-

tween the reality principle and the pleasure principle. It is almost certain that the Buddhist call to robust autonomy and self-reliance, to abandon the hankering after external saviours and magical helpers is imbued with an understanding of "attachment" in the sense of looking for gratifying parent figures in the world. Buddha says: "Be ye lamps unto yourself." "Look not for refuge to anyone but your own selves." "Hold fast to Truth as a lamp." "My action is the womb that bears my destiny." "By his own deeds a fool is tormented." "Purity and impurity are things of a man's inmost self. No man can purify another."

Admittedly there are great differences of emphasis in the varied interpretations which this great doctrine has inspired, just as there have been in the religious differentiations and divisions of the Christian and Moslem worlds. In the many branchings from the tree there has been none more surprising in its living, timeless spirit than the blend resulting from Buddhist impact on ancient China's Tao doctrine—the strange and fascinating tradition of Chan, better known by its Japanese name of Zen.

Whereas the *Gita* and its restatement by the Buddha gave rise to the most complex and abstruse speculative systems and austere practices, very akin to world-denying asceticism, Zen appears to have distilled the essence of the vivifying, life-affirming message, we might say, in defiance of any rational theology or metaphysic. It is the ancient equivalent of our most modern psychoanalytic concept: that of the Here and Now. It proclaims by paradox and by the rediscovery of the beauty and unity of life and of nature in perhaps the world's greatest art—its lights and its shadows—that the secret of the universe is contained in acceptance of everyday reality and a fresh viewpoint on commonplace tasks and situations. I will try to illustrate this in a moment.

We may be pardoned for being frightened and appalled by the austere demands of the *Gita*. Here the liberation of man from pain and conflict is portrayed as residing in what is called giving up "attachment." There is to my view in this doctrine a close analogy to our modern concept of breaking a "fixation" and to the therapeutic goal of maturation by freeing the mind of its immature, ambivalently invested seeking for infantile objects of gratification. By continuing to view the world and present human relations through the distorting lenses of projection of these early ambivalent object-relations, we are carrying the dependence, the infantile demanding, prejudiced, angry unconscious attitudes and feelings forward into adult life. In order to "adjust" to the demands of reality the ego adopts the various mechanisms of defence: repression, identification, re-projection and similar anxiety- and guilt-laden checks on emotional life, which in consequence remains stunted and deluded. As the Eastern sages knew as well as ourselves, one of the outcomes is a false, super-ego morality, covering inner secret rebellion, leading to such phenomena as neurosis, delinquency and its socio-political analogues. Pseudo-religiosity and hypocrisy may be among the symptoms of this split in the personality. The *Gita*, in one notable sentence among many, puts this neatly: "The abstinent run away from what they desire but carry their desires with them; when a man enters Reality he leaves his desires behind him."

Essentially Buddha taught a similar psychology of emanciaption from "desire"—perhaps best translated as "wish" or "infantile demand." Gautama was very aware of guilt and retribution (*karma*)—a kind of self-induced hell of Nemesis that follows

anti-social sexual or sadistic behaviour. His aim was certainly to be done utterly with this kind of unconscious ambivalent thirst for exploiting the object and to replace it by inner realization of the futility of hanging-on, of hoarding and keeping unreal objects of desire. He, like St. Paul, wanted to "put away childish things," realizing the impermanence of all that is, and to live to express the Becoming which is the action of the opposites in the manifested universe. Thus can man feel a conscious part of eternal evolution.

As those who have read *The Secret of the Golden Flower* (introduced to us by C. G. Jung and his commentary) will know, Chinese Taoist religion has a very similar basic concept—that of the unity in opposites which interact to make life slowly perfect itself. Taoism emphasized the limitations of mere morality: from a primordial mystical undifferentiation "the Tao was lost and there came duty to man and right conduct." This is none other than the Fall of Jewish doctrine: the knowledge of good and evil makes man polarize the opposites and so resort to defensive virtue. The quest for integration, for reconciliation, is the finding of Tao. Whereas in the Indian world this quest led to the proliferation of subtlest metaphysical-theological system, in China it led to the perhaps still subtler metaphysic of laughing at these pomposities of high-brow thinking, at becoming the slaves of our own rationalizations. So there is not that forbiddingness about Chinese as there is about Indian deep religion. The Tao is brought to birth in us when we cease to "think about" Truth, or to mortify ourselves, or to burn incense before idols; when, instead, what Christians might call grace quietly dawns, when we suddenly see in a flash what all the bother and conflict and striving has been about. It is that "We are what we have been all the time." Now is this "self-realization" or is it "integration?" Perhaps it does not matter. But it is a reconciliation between man and his universe—man and God— and man and his worst fears too.

Zen, which arose in China as an experience of this blessed state, which those who had it wanted to communicate to whom they could, is best described by this paradoxical anecdote. A Chinese sage, asked "What is the Tao?" replied: "Usual life is the very Tao." He was asked: "If that is so, how do we bring ourselves in accord with it?" The reply came: "If you *try* to accord with it, you will get away from it." At a certain stage, man realizes that theory is of no avail, that theology and metaphysics are no longer important, that they satisfy only his curiosity for a unifying hypothesis *about* the universe and his place in it. They had been necessary to provide him with a base from which to secure a justification for right living.

It is like the need of the child to have a good and clear start with precepts given him by his parents for helping him to deal with his primitive needs, until he can fashion his own, when he must break free. We know how such parental and cultural precepts and deep beliefs can later stand in the way of living life, of grasping experience and its meaning immediately instead of indirectly through the parental values, the stereotypes of convention.

The nearest Christian equivalents for Zen I have to offer (and I doubt not that there are much better ones) are the doctrines of grace and the symbols of the "lily in the field" and of the "kingdom of God within us."

A Zen master, asked where the enquirer could find the Buddha, replied: "It is very much like looking for an ox when you are

riding on one." (This is perhaps why one so frequently sees Chinese sages depicted in sculpture and painting riding on oxen.) A similar pointer to the paradox of Zen experience is this: "If you strive after Buddhahood by any conscious contrivances, your Buddha is indeed a source of eternal misery." Alan Watts says about this: "When we dress in the morning, eat our breakfast, shake hands with a friend . . . this is all full of Zen. It is worth more than all the sacred scriptures in the world . . . , for what are they but enormous commentaries about this one thing which is life? At this very moment all of us are living Zen, and the only difference between ourselves and the great sages is that they realize it and we do not." Hence the words of the Zen poet Hokoji: "How wondrously supernatural and how miraculous this—I draw water and I carry fuel!" "We say 'I live' and the Zen master says 'I live.' The difference is that we have a barrier between the 'I' and the 'live,' whereas he has not."

So such a modern writer as Lin Yutang has written: "I do not think any civilization can be called complete until it has progressed from sophistication to unsophistication . . . and I call no man wise until he has made the progress from the wisdom of knowledge to the wisdom of foolishness, and become a laughing philosopher, feeling first life's tragedy and then life's comedy." This, he assures us, is the fruit of his people's understanding of the synthesis of life.

So also Lin's ancestors, cultivating Zen, have again and again found that what they had been seeking in ideas and books, in moral severity and self-mortification and meditation, had been with them all the time. Life had up to this flash of discovery been like a stupid dog chasing its own tail. "Nothing is left to you at this moment," writes a Zen philosopher, "but to have a good laugh."

In this moment of enlightenment (which the Japanese called *satori*) all the solemn, self-important, angry beating of one's head against a brick wall, all the unconscious *hybris* and wishes for omnipotence, the childish craving for the magical secret, resolve into the insight that there never was a secret that the hostile world withheld from one; that one wasn't any longer the angry rebel or the timid conformist chasing a projection of an unloving God or parent whom one must propitiate or defy. This is a profound religious experience, and results in a new sense of identity and oneness with life. It becomes impossible to want to hurt or force anyone any longer. That infantile desire is dissolved in this moment too.

EASTERN THOUGHT AND DYNAMIC PSYCHOLOGY

While the experience of Gautama at the moment of such enlightenment transfigured him into a Buddha and thus ended the need for a further earthly career, we need not conclude that the prescription for the achievement of enlightment, of *satori* or integration relates only to the sublime level of mastering the unconscious. We cannot guess at what this may mean in a possible world of reality, even though we have, I hope, laid aside the most arrogant of all assumptions—that there are no higher states of knowing reality than what we now know. Enough for us that the concepts and principles are of value to us *here and now*. In the classical period of the great Eastern systems it mattered supremely for men to achieve this knowledge, just as in the last few hundred years it has mattered supremely to Westerners to conquer nature, space and gravity. Their emphasis was at the cost of ignoring the problems of social and economic organization in the world of forms, ours at the cost of the neglect of the

universe of meaning and spirit, each thinking we were the wisest or the most progressive. But now, just as the East has embarked on a technological and social revolution to bring its ancient civilizations closer to the West, so we, on the threshold of mastery of the physical universe, have begun to seek the remedy for our one-sided development. Again—on the principle of polarization and differentiation—we could not know that we could not find integration this way until we had climbed the heights in technical achievement without finding peace or happiness. The West is reaping unparallelled prosperity and physical well-being, but its neurosis and delinquency rates are mounting. "What shall it profit a man to gain the world and lose his soul?" It now matters greatly for us to know how to find our own souls. It is here that I perceive to be the value of the new, raw, groping discipline of dynamic psychology, rooted in biology and medicine. Freud [2] and those that followed him can already point to genuine resolutions of opposed energy systems in the personality through analytic therapy. Synergism and cessation or diminution of conflict results from a humanizing of the super-ego and from an upward flow of the previously repressed, banished forces of the id towards syntony with the thus strengthened ego. It is one of the truly happy experiences of the therapist to witness the flash of *satori*, of insight, when such confluence occurs in a human being—often accompanied by just that wonderful laughter of which the Zen masters spoke. It is followed by an increase in vigour and reality sense. In the course of time there also occurs a corresponding change in the person's relations with his environment. The new integrate does not have to project what he feared in his own unconscious objects onto a world opposed to him in fantasy. *That* is what I would call readjustment. It is not to norms or to old defensive super-ego morality; it is to what was formerly feared and hated but is now seen as but part of ourselves. The adjustment is to psychic reality, disclosing a changed world picture. If we can be the midwives of such events—events which the wisdom of India and China knew also long ago—then surely the ultimate aim of our movement is to do all we can to make it happen often, everywhere, in many human beings.

I do not mean this to imply just more and more psychoanalysis of sick individuals. The process can be parallelled also in the progressive integration of social groups into new entities manifesting new qualities and powers different and superior to their former parts who do not thereby lose identity. The tension of the opposites in the social as against the intrapersonal field is displaced to outgroups, to the "opponent." Our equivalent of analytic therapy is not yet fully apparent, but can be thought of as the "resolution of group tension," and its techniques remain still largely a research goal. The ancients had not got that far either.

Enough has perhaps been said to support my belief that in our new behavioural sciences lies our own modest but exciting beginning of that higher turn of the evolutionary spiral, when ancient, exclusive, recondite *yoga* becomes analytic insight and psycho-dynamic management towards integrating persons within themselves and with each other, and so reconciling them to life in its ceaseless flow and change. That indefatigable fellow worker of ours, Lawrence K. Frank, said ten years ago in London: "We need to develop a field theory of human nature and society which will relegate to the history of ideas many of the older dichotomies and antinomies which

[2] In whose city this lecture was presented.

view men as always fighting against society, or man as the tool of society, or man outside nature, or society as a superhuman power or mechanism ruling over men, and similar expressions of now obsolete ideas." To this list I would like to add the prevalent idea of God—the recipient of every kind of loving and hating anthropomorphic projection men have cared to hang on to the Unknown Source of Being, and all but abandoned by men, not even realizing the projection, as incapable of answering their childish demands, as the unattainable object. As psychoanalysts (as well as many others) would agree, we are indeed in danger of destroying ourselves by super-ego morality, by our own reactive defense mechanisms of compulsive virtues and partial loyalties, under which lurks the wish for rebellion and retaliation without a cause. Outraged nature is taking revenge for its debasement and denigration during a long epoch of history—no less in the ascetic East than in the puritan West, equating the sexual needs and the manifestations of the self-assertive tendency of the human child with original sin while placing a god in a distant heaven.

Recent work in psychoanalysis has shown that the primary, pre-ambivalent dispositions of a child, not yet introduced to restraint and sin, are as much those of love and the desire to give as those of greed and the wish to take. Thus the observations of Melanie Klein and her group infer the existence of a natural morality which reacts quite early with anxiety and despair to its own aggressive fantasies against loved objects. Here lies an important clue to the origins of what the East projected on a cosmic scale: the opposites of creation and destruction, of love and of hate rooted in the social-biological dependence of the human being on its dimly perceived givers of good nourishing things, destined to diffuse into conflict and contradiction (Buddha's desire, the Gita's attachment), and capable, as we now know, of highest flowering or basest self-undoing, according as we now maintain or resolve this fateful battle of light and darkness.

By the very metaphors we use we can see that we are still bound semantically and emotionally to a conviction of dualism, even though we begin dimly to perceive what the integrative union, existing unperceived in deeper reality from the beginning, can mean for the release of love and creativeness in man, whether we call it God or Nature. Zen, the flower of the Eastern evolution of religious science, has foreshadowed this highest kind of human achievement. And it has done so by apparently superseding all that is commonly understood by religion, substituting for it that for which religion has searched—the direct experience of release from bondage of inner contradiction between good and evil, suffering and conflict, here and now, by accepting life in all its aspects because it is of the same nature as its source.

And now we, the youngest and most rudimentary of the sciences of man, have come into possession of an art and a theory which can release these same latent values in Western mankind. Not by aping the East, but in our own way, we have begun to mediate between the opposites in man—his reason and the tabooed rejected part of life, the dirty, untamed, inarticulate gropings of nature in the babe towards selfhood. There are still those to whom this discovery of humble beginnings, of roots in the earth, presents a humiliation and a threat, to be overcome by force or denial. Not for them the gentle wisdom of our longest human civilizations which have never tried to force others to their beliefs. Not for them the most beautiful of Eastern symbols: the lotus, nourished in the mud, climbing

through the dark waters of the emotions until it raises its opened blossom to the light.

At heart I believe that the pattern of life itself is ever striving to such completion, until on the opened lotus appears the serene, childlike shape of the man of perfect compassion in the attitude of benediction. There will be many aeons before our work will be brought to fruition, before we shall see mankind living as Gautama enjoined: "As a bee collects honey but injures not the flower—so let a wise man dwell on earth."

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CHARLES L. ROSE, A.M.

Relatives' attitudes and mental hospitalization

In the recent literature of mental hospital practice a great deal of attention has been given to the way various features of the hospital environment affect the patient (7, 8, 9, 12). At the same time, although to a lesser extent, some attention has been given to those factors which affect a patient's adjustment after he has been returned to the community (1, 4, 6, 11). However, extra-hospital influences on the hospitalized patient—particularly the attitudes of relatives—have received but scant attention in the literature. Observations by those who work with relatives of patients have increasingly suggested that these attitudes may be a factor in maintaining the illness and prolonging the hospitalization.

When a psychiatric patient is hospitalized his relatives develop distinct attitudes toward the illness and the hospital. Indeed, even before hospitalization the relatives have begun to develop special attitudes toward the illness, since the onset of illness frequently occurs some time before hospitalization. With hospitalization, these attitudes become more explicit, and are elaborated to include attitudes toward the hospital treatment program and the hospital's responsibility in the custody and care of the patient. The present paper is a preliminary study of these attitudes.

While this study is not concerned with etiologic questions, it is based on the assumption that the development and main-

Mr. Rose is a case supervisor in the social service department of the Veterans Administration Hospital in Bedford, Mass.

tenance of psychiatric illness is influenced, in part, by emotional ties among family members, that is, the extent to which they have strong emotional involvements with each other. The psychiatrically ill member brings about changes in the behavior and attitudes of other family members. The removal of the ill member through hospitalization brings about further attitude changes, distinct from those which were apparent when the ill member resided in the home.

The present study of relatives' attitudes was undertaken in the social work service of the Veterans Administration Hospital in Bedford, Mass., since the hospital presented unusual opportunities for such a study. In the first place, the hospital was situated close to the population centers of eastern Massachusetts, making it possible for many relatives to maintain contact with the hospital. Secondly, the hospital has admitted patients for the last 30 years, thus providing a setting for the development of prolonged hospitalization. Furthermore, the social work service has over the last decade accumulated considerable experience in delineating and dealing with relatives' attitudes, through its casework program both during and following hospitalization.

METHOD

For this exploratory study a representative sample of the relatives of the hospital population was sought. Accordingly, every tenth patient of the hospital population as of November 1, 1955 was taken in order of admission since the hospital opened. This procedure yielded 180 cases. This sample was found to be representative when it was compared with the known distribution by age, sex and diagnosis of the total hospital population. The relative participating in the study was defined as either the principal visitor (the one who visited the patient most frequently between November 1, 1954 and November 1, 1955) or the patient's next of kin as listed on hospital records, if his relatives did not visit him.

Eighty cases were lost from this sample of 180 cases, leaving 100 cases as the final study sample. The 80 cases were lost for the following reasons:

- In 36 cases the relative refused to cooperate in the research interview. (These were largely relatives who did not visit.)
- In 21 cases the relative lived at a prohibitive distance for an interview to be arranged. (These relatives did visit but infrequently.)
- In 11 cases there was no known relative.
- In 6 cases the patient went home regularly on passes and leaves of absence and was out of the hospital a good deal of the time.
- In 6 cases the patient left the hospital after November 1, 1955 and before the research interview took place.

An examination of the remaining 100 cases revealed that they were similar both to the total hospital population and to the final 10% sample as to age, sex and diagnosis. As might be expected from the above, there was, of course, one difference between the 10% sample and the final study sample—in the study sample relatives visited somewhat more frequently.

The relatives were contacted through an initial appointment letter and one follow-up letter or telephone call. The initial letter was worded as follows: "Through our social service department, the hospital is interested in improving its service to the relatives of our patients. A member of our social service staff would therefore like to talk with you, when you next visit the hos-

pital, concerning your views and suggestions, which would be very valuable to us." In response to this, 80% of the relatives came to the hospital for the interview. A home visit was made to the remaining 20% who were unable to make the trip to the hospital.

The two sources of data were interviews with relatives and hospital records. The object in both the statistical and interview material was to get information bearing on relatives's attitudes, interests and feelings.

The interviews were relatively unstructured to best bring out the feelings of the relatives. The interviews were usually begun with more neutral material, such as attitudes to the hospital, the treatment program, the personnel and the visiting. Through such general discussion the feelings of the relatives were explored indirectly. Later in the interview the relatives tended to express specific feelings quite spontaneously. Thus, after a discussion of the more neutral areas of hospital, personnel, visiting and so on they were able to proceed to the more personal material concerning the treatment of the ill member, the cause of his illness, and their feelings about taking the patient home when he was better. Often when the relatives discussed mental illness and psychiatric treatment in general they inadvertently revealed their attitudes toward the sick member. In some interviews the more personal material could be gleaned only by inference or by the associative sequence of material within the interview.

The interview protocols were analyzed in an informal content analysis. The attitudes selected for presentation were those found to be characteristic of the study sample as a whole. A particular case is cited only when it is representative of a group of such cases.

PATIENTS' CHARACTERISTICS

As in any large established mental hospital, the population at Bedford contains a group of long-hospitalized patients. Thus, in the 10% sample the median age was 50 and the median hospital stay was 9 years. In the study sample the median hospital stay was the same although the median age was only 44. Many of the older patients had to be excluded from the study as they had no living relatives.

The percentages of non-psychotics and those with organic psychoses in the study sample paralleled those found in the total hospital population. Four percent were non-psychotic, 14% had organic psychoses, and the remainder—the functional psychoses—were largely schizophrenic.

FREQUENCY OF VISITING

In the initial 10% sample 22% of the patients who had relatives received an average of at least two visits a month between November 1, 1954 and November 1, 1955. In the study sample 35% of the patients were visited twice a month. The lower figure in the 10% sample was due to the fact that relatives who visited infrequently or not at all were more apt to refuse to be interviewed or lived at a prohibitive distance for an interview to be arranged. As might be expected, older patients and those with longer hospitalization had less frequent visits from relatives. These relationships are shown in the table.

If one regards visiting as an index of interest or concern for the patient, it would appear that such interest or concern diminishes with the patient's age and continued hospitalization even when relatives are living, as is the case in the study sample.

The cases in the 10% sample that received visits were rated as to which relative was the principal visitor. In addition, the

VISITING FREQUENCY	MEDIAN AGE (*years*)		MEDIAN YEARS OF HOSPITALIZATION *	
	10% SAMPLE	STUDY SAMPLE	10% SAMPLE	STUDY SAMPLE
Received at least 2 visits a month	36	35	2	2
Received less than 2 visits a month or none at all	56	54	11	10

* From time of last admission

comparative visiting frequency of the principal visitors was determined. The percentage of cases in which each relative was rated as principal visitor and the percentage of cases in which each principal visitor visited at least twice a month are summarized in the table.

As can be seen, the mother was most often the principal visitor, a reflection in part of the fact that most patients were single. Second to the mother was the sister. In all cases where the sister was the principal visitor, the mother was deceased or too aged and infirm to travel. It was fairly obvious that the sister in these cases was taking over the mother's role in visiting. The low rank of the father may be explained on the basis that he tends to be the oldest relative and does not live long enough to take over the principal visiting role of the mother in the same manner as does the sister.

In addition to being most often the principal visitor, the mother also visited more frequently than other principal visitors. Though the father was seldom the principal visitor, when he was he was second to the mother in visiting frequency. It is noteworthy that as principal visitors mothers and fathers came to the hospital more frequently than wives. Since married patients were younger and had shorter hospital stays, one would expect their wives to visit them relatively frequently in accordance with our general finding that short hospital stay is associated with more frequent visiting. Wives' visiting, however, no doubt diminished earlier than parents' visiting since they had other obligations such as the care and support of children. Yet, wives did visit more often as principal visitor than sisters and brothers.

REACTION TO THE INTERVIEW

There was a consistent reaction of defensiveness to the request to participate in the interview. This was evident in those who

PRINCIPAL VISITOR	PERCENTAGE OF CASES IN WHICH RELATIVE WAS PRINCIPAL VISITOR	PERCENTAGE OF CASES IN WHICH PRINCIPAL VISITOR VISITED AT LEAST TWICE A MONTH
Mother	28	57
Sister	22	17
Brother	13	11
Father	10	58
Wife	10	29
Other relatives	17	0

refused the interview as well as those who cooperated. In correspondence and telephone calls with those who refused, the relatives presented themselves as aggrieved parties (either in relation to the patient or the hospital) and enlarged on why they could not take the patient home. Relatives who did participate in the interview were apprehensive about "some trouble." They were afraid that the patient had done something wrong, or that something terrible had happened to him, or that they were going to be asked to take the patient home —all this despite the initial letter to them which clearly explained the research purpose of the interview.

In the interview itself, anxiety was considerably alleviated when the interviewer further explained that the interview was not for the purpose of taking some action in their particular case but only "to make a survey." They found the role of helping others through participating in a research project was gratifying and reassuring. This effect did not relieve them entirely of their anxiety and defensiveness but it did make it easier for them to stay with the interview.

ATTITUDE TO VISITING

The relatives were asked in the interviews whether they thought they were visiting often enough. Their own feelings in this regard usually did not correspond to their actual visiting. Furthermore, a given rate of visiting would be considered frequent by one relative and infrequent by another.

Those that visited infrequently were defensive about it and felt that the hospital, friends, other relatives and the patient expected them to visit more. Moreover, they tended to exaggerate or were vague about the frequency of their visiting, or invoked as excuses realities of time, distance and money. An example was a wife who visited once a year but felt that she was visiting at an adequate rate.

Those that visited very often were also defensive since they were afraid the hospital might consider their visiting to be excessive. They minimized the visiting frequency and glossed over reality limits of time, distance and money. A typical example was the aged mother who faithfully visited every week by public conveyance and from a distance, yet apologized because she was not visiting often enough.

In a third of the interviews the relatives reported the visiting experience as unpleasant, often describing the patient as insulting or unresponsive. These negative reports usually came from relatives who visited infrequently, but a good many also came from relatives who visited frequently. Some of the major reasons for visiting appeared to be:

- A sense of duty.
- A fear of criticism from relatives and friends.
- To ward off feelings of guilt and rejection from having a family member in the hospital.
- The need to continue control of the patient. An example was the mother who was proud of having been a faithful visitor for many years and who, in her own eyes, was devoting her life to taking care of her child in the hospital.

ATTITUDE TO HOSPITAL

In general, the relatives had lavish praise for the hospital: "The hospital is a wonderful place" or "God bless the hospital for the wonderful care they give." The hospital was regarded as the authority in the care of sick people and this relieved them of the burden. Relatives were hesitant to

criticize the hospital because they didn't want "to get in trouble with the authorities." Also, they did not want to engage in any criticism which might disturb the *status quo,* and lead to their being asked to take the patient home. Only in rare cases did the relative say, "The hospital is a prison" or "The patient is getting worse the longer he is here."

It is noteworthy that while there was little criticism of the psychiatric care, there was criticism about the bodily care of the patent. This criticism was of food, clothing and personal hygiene of the patient. Another group of criticisms were characteristically unreasonable: "The patient should have his own radio" or "The hospital should completely cure my boy" or "Fights (and injuries) among patients shouldn't happen."

A frequent and significant belief expressed by the relatives was that the hospital had "taken over" the patient. This idea was both welcomed and resented, although it was welcomed more than resented.

In general, relatives felt that a gulf separated them from the hospital. They professed to know less about what was going on in the hospital than they actually did. Relatives who visited frequently were more capable of offering constructive criticisms and suggestions. Nevertheless, these relatives basically felt unrelated to the hospital and were similar in this respect to relatives who visited infrequently.

There were the exceptional cases of relatives who had to have complete control of the patient's environment. They visited several times a week, fed the patient, clipped his toenails, inspected his hair. These relatives in addition might even attend the weekly dances held for patients in the evening. Such relatives seemed almost like patients in the way they identified with the hospital and seemed to be experiencing the patient's role vicariously. Unconsciously, perhaps, they were seeking help by exposing themselves to the hospital. They related, however, to the custodial rather than the therapeutic aspects of the hospital. Thus, the hospital as a treatment institution was even to them a hazy and unknown entity.

ATTITUDE TO PERSONNEL

Relatives generally expressed an interest in having more contact with the hospital personnel. When they were specifically asked how much contact they had, a surprisingly large number—about half—admitted that they had fairly regular contacts with the staff, particularly the nursing assistants. Whereas relatives had little criticism of the hospital in general, they had more to say when asked about their attitude to personnel. Their negative feelings were particularly directed to the nursing assistants' physical care of the patients. This criticism was strongly transference-laden in that relatives viewed the nursing assistant as parental surrogates—a fact to be borne in mind when considering the membership of a therapeutic team dealing with relatives' attitudes.

While initially relatives were reluctant to admit their contacts with the hospital personnel, they subsequently admitted having contacts and even voiced a desire for more contacts. They asked how this might come about and, when told, were grateful for the information or admitted they already knew. The writer's impression, however, was that merely informing relatives of their opportunities to talk with the doctor, social worker and nurse was not the solution. It appeared that the relatives did not know how to make the contacts they said they wanted

because they were not predisposed, or actually feared to do so. They were, in a word, ambivalent about their working relationships with the hospital. They were resistive to receiving help and yet showed by their behavior their need for help.

ATTITUDE TO TREATMENT

Relatives professed having little understanding and knowledge of the patient's activities and treatment regime. They had a feeling of distance from the hospital, felt uninvolved in the treatment of the patient, and abdicated to the hospital the responsibility for the patient. When questioned further about their knowledge of hospital treatment they revealed more awareness of treatment, especially somatic treatment, than they had originally indicated. They knew more about drugs, shock treatment and treatment for physical ailments than they did about such psychotherapeutic approaches as individual and group psychotherapy, and rehabilitation activities.

A relative's professed ignorance of psychological treatments may be related to his denial of the emotional factors in the patient's illness. An illustration of this was the mother of a patient who had fractured his leg 10 years ago while in the hospital. This mother insisted that the last 10 years in the hospital were solely for the treatment of the fractured limb, ignoring the more serious psychiatric disability. When she was asked how she would feel about taking the patient home, she quite dissociatively launched into a lengthy and well-documented history of her son's psychiatric symptomatology.

The relatives' feeling of non-involvement in patient treatment militated against their receiving help from treatment personnel. Even when social workers and doctors tried to work with them they tended to be resistive and to discourage such efforts. In addition, they avoided personnel they thought would try to bring about a change in them. Another factor operating to keep relatives and treatment apart was the hospital's policy of focusing on the patient, and the relegation of work with relatives to a very secondary position. The relatives used this reality to justify their feelings of "apartness." Their familiar cry was "Nobody tells us anything." But behind this innocent sounding complaint was a complex hard-to-treat problem.

ATTITUDE TO PATIENT'S ILLNESS

As already mentioned, the relatives tended to deny the existence of mental symptoms. Their characteristic explanation was as follows: The patient came here for a rest, and he was "all right" as long as he was here; but if he left the hospital, he would not be "all right." Hospitalization, then, was used as an aid to deny the presence of illness, and was necessary, apparently on a permanent basis, to maintain this denial. The relatives gave the basic impression that they were mystified as to how the illness was manifested, how it was to be treated, and what caused it.

There were three answers to the specific question as to what they thought caused the illness: "don't know," "the war" and "a physical cause." The three answers occurred with about equal frequency.

Those who blamed the war stated, "Before the war Johnny was perfect, but he returned completely changed. Therefore, the government should cure him or take care of him." They were hazy as to the specific circumstances in the war that caused the illness. In some cases they did specify, stressing somatic factors such as a physical injury, heat, malaria, or other infectious disease. Relatives frequently referred to the fact that the government had adjudicated the illness as being caused by

the service. They were, however, just as apt to blame the war even when the illness was not rated as service-connected. The relatives showed tremendous guilt and disturbance over the illness and were very much predisposed to project responsibility or blame. The war served as a clear-cut, as well as a respectable, explanation for the illness.

The somatic explanations seemed to be part of the relatives' effort to find a simple, concrete, understandable reason for the illness with which they would not be personally involved. By relying on a somatic explanation they were able to avoid more disturbing feelings. The quest for a "simple" somatic explanation was dramatically illustrated by the relative of a patient afflicted with Parkinson's syndrome. The relative believed the condition was due to hemorrhoids.

In the instance of relatives who were not closely related or involved with the patient there was more willingness to consider psychological factors. For example, a stepmother who had recently married into the family, ascribed the illness to a "lack of love, security and understanding."

The relatives were asked what effect the illness had on their relationships with family and friends. The majority stated they felt no stigma and were able to discuss the matter with others. This might be due to three factors: Their own conviction of the somatic basis of the illness, the current community educational program regarding mental illness, and the special community acceptance of mental illness in veterans.

There was less impact on the family life of the primary family than on that of the conjugal family. Since the majority of the patients were single the over-all effect was not grave. Even with married patients, the wives seemed to have made successful adjustments in raising children, in working and living with other relatives. In fact, the relatives' adjustment improved the longer the patient was hospitalized. Free mental hospital care and veterans' pensions to the family also mitigated the effect of the mental illness.

ATTITUDE TO PATIENT'S RETURN HOME

Relatives commonly interpreted the interview appointment as part of the hospital's attempt to get them to take the patient home. They therefore spoke of their feelings on this matter even before the interviewer asked: "Would you take the patient home when he is well enough?" The answer immediately given was "yes," in a scandalized tone, as if the question impugned their integrity and loyalty to the patient. But immediately following this answer they voiced questions and doubts. Characteristic responses were "I have no room," "The patient is not ready," "There is no one to watch the patient," "The patient is well taken care of here" and "The patient might choke me in my sleep. He is harmless but you're kind of scared." Relatives consistently evaluated the patient in terms of his current status, not in terms of possible future improvement. If the patient had recently improved, the relative evaluated him in terms of his pre-improvement status. This denial of improvement, or the potential for improvement, was expressed especially by the relatives who denied that the illness existed.

In a few mothers the denial of the illness had the opposite effect. They wanted to take the patient home no matter how sick he was. Many of them in the past had taken the patient home and provided constant care and attendance. Such patients remained home in an unimproved state sometimes for years. These relatives would reluctantly return the patient only because

of community complaints or because forced to do so by another member of the family. They visited the patient very frequently in the hospital and were always willing to take him home again. They showed even less awareness and understanding of the illness than those who could see the patient only as a permanent hospital resident. Some of these latter relatives also visited very frequently, but for the purpose of "taking care of the patient in the hospital."

While the relatives of the long-term patients resisted the idea of their patient coming home, this was not true of the relatives of the few short-term patients in the study. The reaction of these relatives was more positive, hopeful and flexible. The reorganization of family life had not yet been completed; the patients' hospitalization was still considered temporary and their place in the home was still open. On the other hand, in the case of the long-term patients, the relatives' attitudes showed the adverse effects of prolonged hospitalization. These relatives had reintegrated their personal and community life without the patients, and the patients' place in the home no longer existed.

CONCLUSION

This exploratory study examined the attitudes of relatives that were associated with prolonged hospitalization. A sample of an existing hospital population was studied which contained a large group of patients who had been unable to leave the hospital. Thus, the study was focused on the failures of the hospital rather than on its successes.

The analysis of the findings on relatives' attitudes showed that relatives felt dissociated from the hospital and its treatment program; they regarded the hospital as a custodial institution rather than as a psychiatric treatment setting; they had difficulty in seeing the illness as a psychiatric disorder; they felt hopeless about the illness and resisted the possibility of improvement and, finally, they "closed ranks" in the home against the patient's return (3).

While these findings are in need of further delineation and study, they do point to the need for a hospital program designed to deal with the amelioration and prevention of these attitudes. A preliminary study is now underway on the applicability of the child guidance model for dealing with relatives' attitudes. It is common procedure in the child guidance setting to treat the parent as well as the child (5). A somewhat similar arrangement should be possible when a patient is admitted to a mental hospital (2, 10). It would be part of the hospital admission policy for the relatives to enter out-patient treatment. This treatment would be aimed at the prevention of attitudes deleterious to the patient's recovery and disposition.

ACKNOWLEDGMENTS

Acknowledgments are due to Marjorie Fearing, Frances Hill, Miroslav Kerner, John Matsumuro and Sybil Shapiro, who conducted the research interviews while fulfilling the research requirement for the master's degree in psychiatric social work; to Dr. Jennie Mohr and Dr. Katherine Spencer, research directors of Simmons College School of Social Work and Boston University School of Social Work respectively; to Rebecca Glasmann, chief of the social work service at the hospital who inaugurated and guided the development of the student research program; and finally to Dr. P. Stefan Kraus, director of professional education, and Dr. Leo J. Reyna, research consultant at the hospital, both of whom rendered valuable assistance in developing ideas for the study and in reviewing the manuscript.

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Patients and profits

The hospitals no longer have an unlimited source of cheap labor.

It is even suspected that the few patients assigned are sometimes required to work long hours seven days a week, to help show a paper profit.

How many patients are available for farm work? Could patients be assigned to other areas in the hospital? If they are reassigned will the new activity be of equal benefit? Just why do you need a farm when your job is to treat patients? Does the farm show a profit? If so, how is this possible when your farm employees work 40 hours a week and receive paid vacations and sick leave?—Granville L. Jones, M.D., "Should State Hospitals Stay in the Farming Business?" *Mental Hospitals,* 8 (November 1957), 21–22.

ELIZABETH KANE LYONS

Children--

lost and found

A friend of mine is emotionally disturbed. No more immune to tension and stress than the rest of us, he has lost a sense of direction and has become sick in his mind, in his heart and in his feelings. His problems have sapped his courage and he has chosen the affliction we call mental illness as a means of making his problems bearable. The disease is a kind of way out of his fears, indeed the only route his sick mind tells him is left.

He was a functioning part of our world until the day came when he could no longer cope with his problems. Then he began to see our kind of life as an insurmountable threat to him and, paralyzed by fear of what he felt, he made a life of his own within himself. He will be hospitalized until he is strong enough to abandon his protective dream and accept our world as his own once again.

Just now, as a patient in a psychiatric hospital, there is little to distinguish him from other emotionally disturbed persons sick enough to be confined.

Except that he is a child.

I was aware that mental disease had no respect for boundaries set up by man, but like most well-intentioned persons I never had realized that a child too could live in the bleak borderland of the mentally ill. Yet Sandy, Karol and the other youngsters I met this year have known mental disorder. I worked with them as they learned

Mrs. Lyons writes with skill and perception about the children she cared for as a ward aide in the Nebraska Psychiatric Institute, Omaha.

how to get well, and in this work I have seen that an individual's grapplings with himself and with his surroundings are part of a battle that may be fought and won, and fought again, before he is old enough to go to school.

I had already decided to work as a ward aide in the state-sponsored psychiatric institute near my home when I learned that the hospital had a children's unit. Certainly the concept of mental disease in children was new to my thoughts. While the idea of working with normal children was pleasant enough, I wondered what it would be like to deal with disturbed, lost youngsters every day. The question lodged in my mind and I found myself challenged by it. When an opening on children's service occurred, I applied for the job.

Behind the surge of normal enthusiasm I felt for a new job, however, lay nagging uncertainty.

Introspectively, I wondered if the work I proposed would lead me to a ghost world as dissociated from the vitality of my own sphere as life is from death.

If, indeed, the disturbed youngsters sick enough to be hospitalized were habitants of a dove gray death-world where shadows moved and spoke in censored idiom, where only "safe" persons and objects were recognized by the sick child himself, then where would I be useful? Would I be able to help these children realize that the living world I know can be more attractive than their self-constructed world of flight? My ideals had given way to doubt, but I decided to take the job anyway and contribute to it what I could.

The few psychology courses I had taken in college had led me to believe that work with the mentally ill was a wide-open field, a challege to those who could meet its test. I was convinced that most of this testing would be in my reaction to my patients and in theirs to me. It was they who would be acutely sensitive to whether I passed scrutiny. If I found myself able to love these young patients, and to accept them as fully as I accepted myself, the work would be the experience of a lifetime.

The hospital plant where I was to work was only a few years old, and the children's ward I had visited when I applied for the job was impressively clean and new looking. The youngsters had been off the ward, in recreational therapy, when the director of nurses took me through the area. What I saw that afternoon chased away many of my notions about the world of the mentally ill being a kind of soundless limbo.

Here were crocus-bright halls, restful green and brown bedrooms, a rosy-warm lounge. All was as suggestive of life and light as spring and sunshine.

A small tennis shoe, stray markers from a Monopoly game and the remnant of a pop-gun gave evidence of tumultuous life going on in this ward every day. Only the children's presence was needed to give animation to this scene.

I looked down the quiet hallway, experienced the convent-like stillness of the ward lounge on my tour, and I wondered. . . .

Now all was serene on the ward. I felt self-contained and at ease. But what would it be like when thirty emotionally disturbed children were assembled here? How would I react to thirty behavior problems? Beginning to realize how mistaken I had been in thinking of psychiatric patients, particularly when they are children, in an equation with silence and shadow, I began to feel that I would be anything but poised when confronted by these youngsters.

Walking on the ward that first morning of work, I felt a little self-conscious in virginal white from head to toe. I had felt capable

and adequate in front of my mirror the day before, when I tried on my uniforms. Today I was apprehensive.

It was only a little past 7:00 in the morning, and I got but a glimpse of the dozen or so in-patients. (The day-patients would not arrive until 8:30 or 9.) Looking at them later from my vantage point in the nurses' station, I remembered what the director of nurses had told me. She had explained that these were sick children, as disabled as if polio rather than emotional problems were the enemy they battled.

Tolerance was in her voice, and acceptance and love, when she explained that outward signs of this sickness might be defecation, smearing, even the crude curses so often difficult to accept in a child. Unusual behavior of every kind might be expected in these disturbed youngsters, she went on. She indicated that fears—fear of rejection, even the fear of love itself—might cause or further aggravate the manifestations of the illness.

But, as I was later to learn in ward classes, the children would one day learn to exchange fear and flight for love and self-acceptance.

When this day comes to the child, he is well.

Now it was time for "orientation to the ward," and I followed the young nurse assigned to acquaint me with my surroundings. The first thing we came to when we stepped out of the nurses' station was the ward lounge. The presence of the children made it seem a study in contrast to the same quiet parlor I had visited only a few days ago. Several youngsters, finished with breakfast, had clustered around the television set. Sprawled in the various double-jointed attitudes that only children can assume, they appeared engrossed in this morning's offering by Captain Kangaroo. Among them were the more sedate figures of nurses, aides and an orderly.

Outward calm prevailed for the moment, but before long a dissonance played counterpoint to the television. It began with a low murmur and soon swelled into the strident cacophony of angry young voices. My eyes traveled to a corner of the lounge where two 10-year-olds were having it out, both verbally and physically. Some disagreement evidently had led to a wrestling match and the two boys, flushed and angry as bulls at bay, fought as if by an unwritten code. No ordinary provocation here, I thought, as it became obvious that far more angry feelings than those the two boys held toward each other were involved. Expressions of anger, resentment and something elese were in their faces, making them look as I have seldom seen even adults look.

A small cheering section had formed, and cries of "Chicken! Chicken-fighter!" were heard as one of the boys violated the tacit rules of the fight.

Goaded by the taunts of his peers, young Sandy, the "chicken-fighter," turned from the specifics of his wrestling match to the jeering group near him. He was deeply flushed and sweat glistened against his skin. Anger had seemed to constrict his throat as he rasped out a challenge and a curse to the spectators near him.

"You cheat!" he roared to those who had accused him of a similar breach. "You all cheat. You gang up on me and it's no fair . . ." The boy danced in his rage, and he would have seemed ludicrous had I not seen the mounting passion within him as he went on with his tirade. He seemed possessed by his emotion now as he swung blindly at the nearest patient. An orderly was about to intervene when Sandy's storm broke and in tears he abruptly left the area.

I wanted to find out more about the incident but it was time to visit another part of the ward. Feeling as if I had walked into the middle of a movie, I was puzzled over what I had seen. Why do they have to fight so hard, so unreasonably, I wondered.

As the months passed I was able to gain insight into this and other incidents by attending the weekly ward classes conducted by a staff doctor on children's service. In this class, and in another weekly group session with the ward supervisor, I began to see that with my two fighters, and in a vicarious way with their small audience, a young lifetime of feelings had perhaps come to the fore during the fight and the ensuing upset. It was as if a normal, boyish way of settling a dispute had been used to act out painful, pent-up emotions . . . feelings about situations which might have little to do with the surface disagreement but which bubble like boiling water under a tight lid. Those of us who are not sick find acceptable, even constructive ways to release uncertain waters that churn within us. We remain well because our safety valves are in working order. However, for reasons native to each case, these youngsters seem not to have discovered their special valve, or perhaps the safety release has become clogged and useless. As the healthy avenues close off, the child begins to grow sick inside. The pressure swells and must find room within. When there is no more space to contain and control this force the young patient seems to find his only solution—in mental illness. If by nature he is an especially aggressive child, in his illness we find him full of fight and bluster. Like Sandy, the "chicken-fighter," he shakes his fist at a world he sees as fickle and unfair. If he is of a more timid nature, we find in him the desire for flight rather than fight when he becomes sick. He seems to cower and cringe until his arc-light of communication is confined to a lonely beam inward.

I saw an illustration of the contrast between angry patients like Sandy and the frightened, withdrawn patients like Lanny and Tim as we approached the boys' wing on our orientation tour.

In the exact center of the hall twirled a young dervish, minus only the baggy pants of the costume to complete the picture. Arms outstretched, hands clasped, lips in a compressed smile, 7-year-old Lanny spun round and round, never seeming to become dizzy, never straying from the pinpoint area of floor he occupied.

In charting this behavior, as we did several times daily in the hospital, we might have referred to it as "inappropriate" and "not relating to the group." Generally, I considered these psychological terms to be classic understatements, and in association with this little boy, "disconnected" was the word that more specifically came to mind. He had a private orbit on the ward, and I was frequently struck by the abstract loneliness of the path Lanny traveled. He seemed so completely frightened by every person, every stimulus around him that he had withdrawn to another, safer place within himself, literally severing his thoughts from contact with daily life. When one of us did get close to him he wheeled off into his silent dance or, as a final weapon of defense, produced bowel movements with incredible frequency. Only the most heroic of the staff members could withstand these onslaughts of feces when making an effort to get through to Lanny. I was to see the patient's awareness increase to the point where he could show at least passing interest in the colored pictures of a magazine and could feed himself without smearing half his dinner into the table-top.

But he is still a patient and as the months pass his progress seems dishearteningly slow. Like the baby unwilling to be born yet, he hesitates to leave his secure, womb-like world for the comparative hazards and obligations of normal life.

Near Lanny crouched Tim, the little colored boy whom I was to meet more formally later on. He, like Lanny, was one of our "quiet ones." In silence, he tore sheet after sheet of paper into slender strips with fingers as sensitive as those of a violinist. He seemed to have a need to destroy, but in his withdrawn state he was able to express this only by silently tearing to ribbons all the paper he could find. Small heaps of his destruction now lay around him and he murmured to himself as we came by.

When we were later introduced, his forehead puckered and he cried, "Hold him!"

"Hold . . . who?" I asked, bewildered.

"Hold *Timmy*!" Tim responded, and only then did I catch the personal reference. Tim was to become much more outgoing and responsive as his therapist worked with him, but the improvement I found most gratifying was when he seemed enough united with himself to use the words "I" and "me" instead of "Tim" as if Tim were some other, less desirable person.

Sandy, too, showed improvement as his doctor treated him. Over the weeks and months he found it no longer expedient to be a cowardly fighter. As he learned more favorable ways of gaining attention, he began to show sparks of the puckish, lovable Tom Sawyer that lay within him, crying out for development.

My guide now led me to the girls' wing where we found a game of Chinese tag in progress, and I saw an older nurse hopping about on one foot in her attempts to tag a plump teen-aged girl who barely eluded her. Everyone seemed to be having a good time at the game, and it was difficult to remember that these laughing girls were mental patients.

As we passed the bathroom I saw a young girl posturing before the mirror, peering at her image and giving her black pony-tail frequent tosses as she struck a variety of poses.

Not too exceptional, I thought in passing, remembering my own pre-adolescent gazings before the mirror.

Left to my own devices for a few moments in the nurses' station, I reflected that many of these children were not too different from the "normal" ones I knew . . . except that everything they seemed to do and think and feel was more intense, a kind of magnified reflection of the norm. Looking at it in this way, I felt more sure of myself in this job, more ready to meet whatever might lay before me.

As the days of my first month on the ward came and went I began to notice that some of the patients tested me, as if they wished to "feel me out," to see whether I could be trusted. They seemed to wonder if I would be "on their side" or "just another stinker" to fear and mistrust.

Karol, self-styled leader of the older girls, seemed to go to considerable effort to place me on trial. Each morning when we met she and Sherry, her cohort, would greet me with a foul obscenity. In the crafts room she would regale us with a running fantasy filled with four-letter words. As the days passed she seemed to reach more desperately for unacceptable vulgarity until one morning she threw down the apron I had given her to stitch and declared in obvious exasperation, "Doesn't *any*thing I say shock you?"

Wanting time to think, I temporized: "Do you want to shock me, Karol?"

With a brave laugh she said she "loved shocking people."

Having heard of the bizarre behavior in high school that had finally led Karol to the hospital, and sensing the desperate bids for attention that might be concealed by this, I observed that "maybe I think what you have to say is worth-while enough so that I want to hear it in spite of the four-letter words." She was silent, for a change, and then I noticed her blush and the vein prominent in her forehead. I led the conversation to other channels to give her a chance to think about our encounter.

Later I discovered that Karol had a fine, if untrained, singing voice, and one of the nurses and I worked out a sometimes successful arrangement to have her sing whenever her language became intolerable. She grew more companionable and as her confidence in herself increased she began to lead the girls in group singing and to use her natural talent as a leader in this pleasant way.

Karol is an out-patient now, unconnected with the hospital except for her weekly sessions with her doctor, but she stands prime in my memory for helping me learn my first real lesson in dealing with these youngsters: that a strong feeling, represented by an unacceptable action, may be channeled into an acceptable outlet. Karol's foul obscenities, for example, could sometimes be converted into a melodious contralto singing voice which made a pleasant addition to the group. As she sensed her power to please, she became more accepting of herself and in turn was more agreeable to others.

There was satisfaction in seeing this. But for all of the rewards I began to know there were as many stinging disappointments. If I made a mistake in handling a patient, I was to learn that I must live with that mistake and work it through day after day until the situation was resolved.

Countless times, through ignorance, impatience or mere lack of perception, I would lose touch with the patient whose confidence I had sought for weeks. The result of my error was sometimes a complete shut-out of me by the patient, sometimes a negative contact established by the child, who would act out his feelings against me and the authority I represented by way of tantrums, a jab in the back during some game, a smashing of hospital property.

As I became acquainted with the aides and orderlies at the hospital, I heard among them the maxim that "if you can last the first two weeks on the ward, you can make the grade. If you can't you'll know it sooner than we do and you will want to leave."

By the end of my first few weeks on the children's service I had come to know many sensations.

I had experienced consuming physical weariness from playing tag and "Capture the Flag" regularly (for the first time in fifteen years). And I came to know the mental fatigue that results from having to absorb situations and sights and sounds never before encountered—and, so it seemed, now met at the rate of about one hundred a day.

As the months passed I realized a sense of growing revulsion at the giggling Lanny who played in his bowel movements as I tried to clean him up. I came to know bewilderment with Dave who spent his waking hours trying to run away from the hospital so that he could set fires, an unhappy tendency of his that had originally brought about his hospitalization.

And I learned the feeling of unalloyed pity when we admitted Anna, who at five months of age had discovered the futility

of crying when her wails went unheeded in the slovenly boarding home that had housed her since birth. This baby who came to us had forgotten how to cry. She lay on her back, silent and pathetic, scarcely able to lift her head. Anna had lived nearly half a year, yet the scales showed her only slightly over her birth weight. Doctors' examinations had shown no physical cause for her condition. Ward orders for her were simply to give her as much cuddling and cooing, as much mother-love, as possible. We all spent every available minute giving her the affection for which she was starved, and in three months' time she was sitting up unaided, laughing at our efforts to amuse her, crying vigorously when the need arose and gaining weight every week. The pity I originally felt for this infant has been exchanged for the pride we all felt in her when we learned she would soon be ready for normal adoption.

These varied reactions to our "little children lost" are perhaps less positive than the one response which has grown to surpass all others. As the months pass, the feeling flourishes and matures like the love of mother for child. Quite simply, it springs from being able to help fulfill the thirsting need of a stunted youngster to grow again.

In ward classes held for the aides and orderlies every week I have learned to utilize my own assets and emotions in helping our sick children acquire health. Expert, trained assistance is always at hand to help us know our patients, and indirectly to know ourselves so that we will be of maximum value in our role. Some of the classes are devoted to learning all that is pertinent in the background of specific patients. In an effort to learn something of "how they get that way" we discuss summaries of the child's home life, situations in the past which may have had a traumatic effect.

In other classes we partake of a kind of group therapy, where each of us on the staff agrees to respect the other's confidence so that we might speak honestly of our individual problems with the patients. These sessions, sometimes lively with argument, are like the functioning safety valves I mentioned earlier: by frankly discussing our methods in dealing with ward situations, and our inner thoughts about these actions, we learn to read our own hearts with knowing eyes. We begin to recognize the "why" of our feelings and with this self-knowledge comes significant understanding of the patients. Perhaps in this area lies the keynote to satisfaction in my work.

As much as I think I give these youngsters, in empathy and in love, they give in return, to the fullest measure. Even as we have helped the children grow, so they, in their acute perception of us, permit us to grow with them. Is it worth the occasional indignity to the adult spirit, the less than astonishing pay, the minor hurts to pride, the exasperations, the fatigues, the tensions? Growth, at any price, is worth it for the children . . . and for me. Like the parent who fosters independence in his child and foresees the time when that child has grown enough to leave the nest, I feel a pang at the departure of the youngster to whom I have given much.

But this sense of loss is the signal of my reward. Only when the youngsters have received enough from us to be able to leave us can they be considered nearly well. And the patient's wellness, his long-awaited growth, is our final pleasure. As the child has matured, so have we.

ELAINE CUMMING, PH.D.
JOHN CUMMING, M.D.

Two views of public attitudes toward mental illness

It is possible to look at public attitudes toward mental illness from many vantage points. We are attempting here to synchronize an academic sociological analysis with a practical therapeutic one in the hope of better appreciating the social context in which therapists work to mitigate the suffering of the mentally ill. We have, in the past, successfully used this double-barreled onslaught upon the stubborn problem of the relationship between the mentally ill person and the society from which he has been ejected.[1]

A sociologist, by definition, is trained to analyze problems from the social perspective. He does not, of course, question that mental illness is primarily a personal and interpersonal problem, but he focuses upon its impact on society. It is to him a special case of the social control of deviance, which is itself one of the all-pervasive problems of social living, and it is in this light that he analyzes it.

At the time this article was written Dr. Elaine Cumming, a member of the faculty of the University of Chicago, was completing a research study of mental health in Kansas City. She has since been appointed to the post of sociologist in the New York State Department of Mental Hygiene, for which Dr. John Cumming directs a research unit in Syracuse.

This is substantially the text of a 2-part speech delivered by the authors March 27, 1958 at the annual meeting of the New York State Society for Mental Health.

[1] Cumming, Elaine and John Cumming, *Closed Ranks*. Cambridge, Harvard University Press, 1957.

Opinions and attitudes about how deviance should be controlled are variable; not only are there more than one set of acceptable attitudes toward deviance at any one time but there tend to be long-term trends of change in these attitudes. During these long-term changes we in the mental health movement often sustain quite serious losses. We lost a lot, for example, with the shift from moral to medical treatment of the mentally ill, and currently we may even be losing some very humane skills for handling disturbances because our revolt against the "custodial" approach to treatment has been so thorough that we are tempted to believe no one whose goal is peaceful custody has anything to teach us.[2]

There is a basic problem posed for everyone whose work hinges to any extent upon the public temper, and it is this: "How can we best control the effects of an attitude shift so that the change does not run away with itself? How can we dampen the swing of the pendulum so that its arc is not too wide?" The reverse of this question is more often heard. We are accustomed to asking what will happen if we become so concerned with conserving balance that we do not allow new ideas to get established and new techniques to show what they are worth. But now that we have made so many gains in the struggle against mental illness we are probably ready to entertain the question of how to conserve our gains if there is any marked swing in the public mood. Before considering examples of the kinds of swing which can affect our programs we should have some way of thinking about the extremes to which the pendulum can swing.

It is possible to identify two general styles in which deviance can be handled. It is hard to find 1-word labels for these differing viewpoints—we might call them the firm and the soft approach but the word "soft" is invidious. William James's famous tough-minded versus tender-minded is useful but here the word "tough" carries the wrong flavor. Bertrand Russell uses two terms to describe an ancient and persistent division between philosophic schools—the disciplinarian versus the libertarian[3] and although we cannot use the words precisely as Russell does, they are near enough to represent a pervasive difference between two equally ethical attitudes toward the deviant members of society. Most members of mental health associations, for example, will find themselves identified with the libertarian point of view so we will try to stress the other one, partially to balance the argument but partially because it is probably the viewpoint of that uninvolved majority of lay people whom we call "the public."

THE DISCIPLINARIAN

Disciplinarians put the good of the whole group ahead of the good of any individual and hence they treat deviance as a threat to the general good. This means that they focus treatment upon the restoration of group equilibrium. Their approach is on the whole a conserving one rather than an innovating one—they value the past and traditional ways of handling problems. Above all, they value social cohesion. New ideas are examined in terms of whether or not they will undermine the established order, for the disciplinarian places a high value on law, order and predictability. Heroism, courage and nobility are prized

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[2] See in this connection, A. Stanton and M. Schwartz, *The Mental Hospital*, Glencoe, Ill., Free Press, 1954, 44–88.

[3] Russell, Bertrand, *A History of Ancient Philosophy*. New York, Simon and Schuster, 1945.

virtues to people with this orientation. The Victorian family is one example of a small subsociety with a fundamentally disciplinarian ethos. Another is revealed in an excerpt from a medical textbook of 1889: [4]

"In most forms of insanity the physician risks very little by positively recommending asylum treatment. He has three important questions to consider: 1st, the safety of the society; 2nd, the physical and financial safety of the family; 3rd, the interests of the patient as an individual. Ordinarily the duty of the physician is in the first place towards the individual patient; in the case of insanity, however, there are many other interests than those of science, and of abstract humanity to the patient, involved. Where we have to choose between endangering the security, health and happiness of healthy and useful members of society on the one hand, and the compliance with sentimental considerations advanced in the favor of decrepit, dangerous or possibly useless ones, we need not hesitate long in our choice."

This orientation is by no means old-fashioned, however. As far as attitudes toward mental illness are concerned, there is reason to believe that the necessity for predictability in social life means that most of the people most of the time do espouse this very attitude toward all deviant behavior, including mental illness. Furthermore, just as the disciplinarian values a cohesive society, a cohesive society is characterized by disciplinarian attitudes. Furthermore, societies become more cohesive when they are faced with a threat from an out-group. Therefore, it is likely that disciplinarian attitudes will prevail when a country feels threatened from the outside. Whatever a realistic appraisal might be, we have had periods of feeling relatively disadvantaged in the last few months! [5] There have been many signs in the mass media of a recent re-emergence of the disciplinarian spirit, especially in attitudes toward education and the handling of delinquency, areas in which during the last twenty or thirty years the disciplinarian influence has seemed small. Before analyzing this shift any further, however, let us outline the main characteristics of the opposite point of view.

THE LIBERTARIAN

The libertarian cherishes the individual above the group and feels that society derives its justification from the happiness of its members. Because he has nurturant attitudes toward deviance he channels his efforts into programs which are aimed at amelioration of the individual's plight. He feels that the group can thrive only as the least of its members thrives with it. Libertarians in general look upon love and cooperation as higher virtues than courage and heroism.

This is the point of view which inspires men to cure the incurable, to help the unhelpable, and above all to redefine the wicked as ill, mistaken or unfortunate. The deviant then becomes by definition a candidate for help in returning to the community as a functioning member. This point of view undoubtedly sustained Dorothea Dix, John Howard and other great humanitarian reformers in their labors. This is the ethos which opens mental hospital doors and installs counselors in prisons; perhaps most significantly it inspires

[4] Spitzka, E. C., *Insanity, Its Classification, Diagnosis, and Treatment.* New York, E. B. Treat, 1889, 397–98.

[5] This paper was first written in late 1957, year of Sputnik.

individuals to band together voluntarily in organizations devoted to the realization of the best available life for everyone.

Now it seems inescapable that all societies must have both of these elements. We all must make some sacrifices for the general good, but at the same time we cannot exist happily without a considerable value upon the individual. Indeed, in a classical study the great French sociologist, Emile Durkheim,[6] showed that suicide rates go up when the constraints that society exerts upon its members become either too great *or* too few. There is no doubt that we need for harmony both of these points of view. The trouble is that when there is a change—and sometimes only a small one —in the proportion of people subscribing to each side the shift in the underlying feeling can bring a considerable upheaval of the superstructure. We suddenly become aware of all of our old shortcomings and are off to a fresh new start, and the first thing we know we have thrown out the baby with the bathwater.

Our first concrete example of changes in public thinking comes from the field of genetics. During the early part of this century there was a great following for the belief that it was necessary to sterilize the unfit in order to reverse the so-called differential birth rate which was thought to be lowering the national intelligence. The disciplinarian view was in the ascendency; people were alarmed about the ultimate fate of the race. This anxiety had been fed by an inadequate understanding of the new science of genetics and by fear of the ultimate effect of the open-door immigration policy. Frightful tales of the subhuman Jukeses and Kallikaks rang out in the lecture halls and people became truly alarmed to hear them. For a time it was believed that the biological stock was indeed being rapidly degraded. This belief arose from a confusion between heredity endowment and a number of such factors as poverty, culture and the ability to speak English. Pamphlets exhorted us to work for new immigration laws. A number of popular books advised us how to select marriage partners so as to conserve the best qualities of the race. University graduates were particularly exhorted—apparently with success—to do their bit for the population. Eugenics societies succeeded in arousing the public sufficiently to ensure the passage of sterilization laws in some states.

Now what has happened to all this? Who talks about sterilization of the unfit now? Several things happened: we learned more about the subtleties of population genetics, and the Nazi gas chambers taught us a sobering lesson. However, even before we had these pieces of evidence, and all the time the eugenists were at their zenith, there were minority voices to be heard. Certain religious bodies, as always, opposed sterilization on moral and theological grounds. There were ethical protests, too. Some persistent libertarians were asking why a dull-normal mother who cherished her children should be deprived of her right to motherhood in the interest of the national intelligence level. Others were raising the question, "What is the good of people being so clever when they are often at the same time so cruel and inhuman?" Furthermore, and this is very important, there was another thread of discord. A few voices were raised within the ranks of the geneticists themselves. At the height of the Kallikak family's fame as the most dreadful example of what we were all headed for

[6] Durkheim, Emile, *Suicide*. Glencoe, Ill., Free Press, 1950.

Lionel Hogben[7] pointed out that the evidence upon which the degraded genetic state of this colorful family rested was extremely unscientific. After sifting it carefully he announced that it proved very little about their natural endowments—the most that could be said for sure about them was that they were very poor and that some of them drank to excess. Nowadays we would say that what they needed was not sterilization but rehabilitation! The most instructive feature of this story seems to be that there were people, probably both libertarians and disciplinarians, who did not make up their minds until they had a satisfactory body of evidence upon which to do so. As a matter of fact, many other voices[8] soon joined Hogben's, and before long the whole edifice had toppled.[9]

MODERN EDUCATION

This has been an easy example to analyze and discuss because we have quite a long perspective on it. A somewhat hotter issue is the standard of modern education. In some ways education shares elements with the treatment of the mentally ill. One trains and the other restores members of society to a certain level of conformity, and it is therefore useful to discuss them in the same terms. Some of us have seen in our lifetimes the old grammar school inherited from the nineteenth century go down before the prolonged liberalizing movement of progressive education. We remember the old system in which teachers taught subjects. Later, children had teachers who declared somewhat sanctimoniously that they taught "not subjects, but children." Recently we have been able to say, "This is fine, but surely they must teach them something," without being branded as reactionary.

Suddenly we seem to have reached a watershed in education. The new trend is toward challenging the child's intellect; there is a shift in focus from the well-adjusted child to the well-educated child. Nobody wants to return to the hickory stick but some people are remembering that while the old grammar school system didn't "take" on all children, when it did it left them thoroughly and permanently educated.

How widely will the pendulum swing in educational methods? It is easy to be swept away with enthusiasm for a new and better system and to say that naturally we will retain the virtues of the softer methods while returning to the tougher curriculum. We may do well to watch closely the way in which the newer approach takes account of exceptional children. The libertarian approach always concerned itself very much with the child in trouble; dull children fared very well—when there were facilities—under this régime. The troubled child, the shy child, the bully, the coward, the nail-biter, the show-off—all of these children were thought to need special care and attention. The success of the system was reflected in how well it coped with its weakest members.

Under a disciplinarian educational system attention turns to the good of the whole

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[7] Hogben, L., *The Nature of Living Matter*, New York, Alfred Knopf, 1931.

[8] See, for example, L. C. Dunn and Th. Dobzhansky, *Heredity, Race and Society*, New York, Pelican Books, 1946.

[9] It is interesting that Sweden has for many years had a eugenics program in which sterilization is available to certain parents who request it. The decision has been partly in terms of the public welfare and partly in terms of individual wishes. It has never, apparently, been a *cause celebre*, and it would be interesting to examine, in the light of our own and Germany's experience, why this is so.

group and hence quite logically to special provisions for those who can contribute most to the whole group—the brighter children. Programs to accelerate them and to meet their special needs are suddenly in the limelight. The educational system has a new measuring rod; it is no longer so concerned with remedial work but more with the number of truly well-educated adults it can produce from among its gifted members. While this splendid goal is a great relief to many parents the question of whether the dull and the troubled and the less fortunate will be considered relatively expendable because of this change of emphasis is still unanswered. Will they be left to shift for themselves in the same way that the gifted ones—who are much better able to do it—have until recently had to shift for themselves? [10]

The eugenics movement is history, while the struggle to strike a new orientation in education is very much with us. By the time it is settled there will be new areas of shifting values. Recently, for example, there seem to have been signs of a swing away from the great enthusiasm for psychoanalysis which marked the years immediately after the war. The trend, if it is one at all, is too new to be easily understood, but it would be a pity if a reaction against a certain extreme psychoanalytic orthodoxy causes us to lose sight of the many creative therapeutic insights it has given us.

It is easy to oversimplify this problem. It would be nice if we could always do the reasonable thing. Or would it? The Greeks in an excess of reason sometimes sat and argued about problems which only action or investigation could solve. At times we seem to need to have causes and to take sides in order to get off the ground at all. The zeal and conviction of Dorothea Dix resulted in such an alleviation of suffering that her example in itself seems sufficient to justify a strongly partisan position. And yet we know that sometimes—as, for example, in periods of extreme zeal for the surgical treatments of mental illness—caution would serve us better.

For lack of a formula for using just the right mixture of reason, enthusiasm and circumspection we will turn now, after posing the general problem of shifting public temper, to a brief consideration of some of the specific precautions against losing the baby with the bathwater that those engaged in the healing arts might take.

THE CLINICAL SCENE

The general division of the public into disciplinarians and libertarians has a number of specific counterparts, especially in the field of mental health. Greenblatt, York and Brown [11] distinguish in the title of their book between custodial attitudes and therapeutic attitudes. We, in another place,[12] have used a similar distinction, that of traditional versus rational attitudes. If we examine all these dichotomous sets of words we notice that there are pronounced similarities among the more conservative of each pair. The words "traditional," "custodial," "disciplinarian" and "tough-minded" all suggest similar ways of acting. The similarity is not so marked, however, if you look at the more liberal member of

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[10] It would be interesting to know whether philosophers of education have a "collection" of schools which have gradually liberalized their methods during the last two decades without abandoning the intellectual rigor of the older grammar schools?

[11] Greenblatt, M., R. York, E. L. Brown, *From Therapeutic to Custodial Care in Mental Hospitals.* New York, Russell Sage Foundation, 1956.

[12] Clancey, I. L. W., J. Cumming and E. Cumming, "Training Psychiatric Nurses—A Re-Evaluation," *Canadian Psychiatric Association Journal,* 2(1, 1957), 26–33.

each pair. The terms "libertarian," "tender-minded," "therapeutic" and "rational" all seem to have one main feature: they are set in antithesis to attitudes which tend to maintain the *status quo* and they therefore contain the common element of innovation.

But the matter is not this simple, for as the number of words we use implies there is more than one style of innovation. Furthermore, there is a possibility that we can combine certain pairs of attitudes which do not ordinarily cluster together; there is, for example, the possibility of a tough-minded libertarianism. Furthermore, although all innovators have probably at one time or another worked very hard for change we have to admit that innovation for its own sake is not always salutary. This was very evident to us recently during the planning of an experiment designed to demonstrate that certain changes in the social milieu of the mental hospital would result in marked improvements in the patients' clinical condition. Four groups of 10 schizophrenic men, none of whom could be severely handicapped or suffering from organic brain damage, were called for in the design. Surprisingly, it transpired that out of the 1,000 male patients in this hospital we could not find 40 men who met this specification. The reason was that some years before a misplaced enthusiasm for a new technique called trans-orbital lobotomy had found favor in this particular hospital and literally hundreds of these operations had been performed. To be fair, there was no evidence that any of these patients were rendered less salvageable by these operations, but it is quite certain that they had not been helped.

There are other examples of innovations made with the best of intentions and in a libertarian mood which we prefer now to forget. Part of the obligation that those who play professional roles in this process of innovation must assume is that of moving with great care and of making full use of all of the fields of science which are available to us for evaluating what we are doing before we apply our new methods generally. We have a rather conservative medical rule governing us which lays down, as a first principle of treatment, "do no harm" so that we must always temper our innovating impulses with caution.

We are, however, dealing with two sets of variables in this analysis. There are the activities of such innovators as ourselves in our effort to better the care and treatment of the mentally ill, and there is the public attitude with its pendulum swing between disciplinarian and libertarian moods. What effects have these attitudes upon the work of the innovator? When the climate of public opinion favors a more conservative tendency the work of the innovator is undoubtedly harder. He gets fewer grants and less encouragement, and he is often required to demonstrate so thoroughly that his ideas are logical and safe that adequate testing is difficult. On the other hand, when public attitudes are more libertarian the innovator finds a much more sympathetic hearing for his point of view. He finds it easy to raise funds, he is encouraged in his undertaking, and, in fact, at times he is pushed by public sentiment and by legislators into doing things before he is really ready. He is encouraged to apply on a large scale discoveries which may really need retesting and verification. Most importantly, there is a danger of the innovator's becoming confused between the complexities of his own work and the simplicity of the slogans put forward by the lay proponents of change. There is a familiar example in child-raising practices. Many of us have had experience with several types of child-raising; some of us remember ech-

oes of the "children should be seen and not heard" school, and all can probably recall the period of focus upon the dangers of frustrating children. This coincided with a great upswing in a libertarian orientation toward child-raising.[13]

In recent years there has been a new change. We have heard less about the dangers of frustration and more about "setting limits." Children are said to be unhappy if they are allowed complete freedom of expression and to become anxious in ambiguous situations. This has been widely interpreted as a middle-of-the-road policy. It is a rather comfortable, somewhat uncommitted position to take—a middle position for middle-class people—and best of all, it seems to work.

Now it is true that the setting of limits is intermediary between the old authoritarian and the newer permissive methods, and to this extent it is a middle-of-the-road philosophy. But it is not simply a case of the pendulum coming to rest in the center after two extreme swings; it is also a case of the discovery of a new dimension of behavior.[14] The newness consists in the idea of "limits" implying that the social situation is going to be a continuing interpersonal relationship which will concern itself in part with the idea of freedom and of limits to freedom. Finally, the idea of "limits" implies that there needs to be a lack of ambiguity about our social lives because ambiguity is anxiety-provoking, and this is a new idea. In short, the concept of person-in-the-situation [15] has been added to the older dimension of the inner development of the child. The idea of limit-setting involves a more complex idea than that of simple compromise between extremes.

This concept of person-in-the-situation has been extremely important in the newer milieu therapies which we have employed so successfully with the mentally ill. In most state hospitals for many years patients used to be thought to be of two kinds—good patients who were docile and bad patients who were rebellious. In the traditional hospital docility was rewarded with a narrow range of privileges and rebelliousness was rigorously controlled and sometimes even anticipated before it appeared because it was thought so important to control it. There is a scarcely credible example [16] in a mental hospital where for some reason it had been decided that the patients diagnosed as hebephrenic were a potentially dangerous and rebellious group. As a consequence of this belief, particular care was given to the handling of hebephrenics.[17] They were kept together on one ward and every day they were taken together to a walled exercise court. Because it was thought that they were potentially disturbed, they were not allowed to move around freely but were distributed on benches around the court. If a patient tried to get up, this was taken as evidence that he might be becoming disturbed. As the attendants had been taught that if one per-

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[13] An example of the extent of this strongly held libertarian belief among the laity is given and discussed in the authors' *Closed Ranks*, cited above.

[14] For a lucid and dramatic comment on the vital difference between "the swing of the pendulum and the motion of growth," see Lionel Trilling's *The Middle of the Journey*. New York, Viking Press, 1947, 299–300.

[15] For early statements on the importance of this concept, see Lois Murphy's *Social Behavior and Child Personality* (New York, Columbia University Press, 1937) and H. S. Sullivan, *Conceptions of Modern Psychiatry* (Washington, D. C., William Alanson White Foundation, 1945).

[16] This story was related by D. I. L. W. Clancey, who uses it as an example of Robert Merton's principle of the self-fulfilling prophecy.

[17] A group of psychotics not generally considered aggressive.

son became disturbed others might quickly follow, any patient showing signs of wishing to move out of his place on the bench was restrained immediately by several attendants. If he then became frightened and in his fear tried to fend them off, he was quickly subdued and returned to his place in the circle. By such quick action was disaster averted, and each time this happened a mistaken belief was reinforced.

In many hospitals for many years practically all effort was spent in preventing trouble before it occurred. This resulted in patients' living in environments which were often highly ambiguous, in which demands must often have seemed contradictory. In such an environment attendants did not define the patients as legitimate objects for personal relationships, patients were discouraged from having personal relationships with one another, and there was only the most impoverished, fragmented, rudimentary social structure. It is easier now to see how patients became desocialized and how chronicity set in, because we now understand the new dimension of patient-in-the-situation.

A few hospitals have faced the problem of the years of chronicity which they have inherited with great courage and intelligence. It is not an easy task to change a hospital of this sort, because the whole administrative structure has gradually come to be in accord with the old system. This may have to be changed—and changed against resistance—before a new system can be brought into effect. Anyone who knows the traditional mental hospital knows the profound feeling of inertia which permeates it. On the wards the people who have been trained to consider one set of actions right and proper have to be convinced first of all that new ways of doing things are *possible;* then they have to feel that it is *worth while* trying to change, and finally they must believe that they will be *rewarded* for changing. Once they decide this, they have to go through the difficult process of learning new ways of interacting with patients. They must be given leadership in establishing a new social structure around the patient groups. To do these things is incredibly hard, time-consuming and often frustrating, but it is very rewarding. When it is done—and it has been done in a large number of places—there are dramatic changes; the stillness leaves the chronic wards as the patients become social individuals again, as they begin to accept social responsibilities, and as they become more cooperative and sociable. Out of these changes come such innovations as patient government, the open-door policy, and the use of volunteers. Finally, when all of this work and effort has gone on, there is public acclaim for the progress. If the story is written up in the press more than likely its central theme will be the amazing fact that mentally ill people can be kept in hospitals without straight-jackets or other restraints, and with the ward doors unlocked. The open door will have become a symbol for the change as the phrase middle-of-the-road has become the symbol for a fundamentally new approach to child-training.

But there is a problem in this development of a symbol.

Perhaps the most famous example of the open hospital is that of Dr. T. P. Rees at Warlingham Park in England. It is said that it took Rees seven years of diligent work among his staff to develop his treatment policies to the place where he wanted them to be. At the end of this time the success of the treatment must have made the open hospital merely a logical extension of all that had gone on before. But Warlingham Park is *not* famous for being a hospital with very high standards of treat-

ment; it is famous because none of its doors are locked.

Thus we can see how a complex process involving constant therapeutic effort and the continuous use of rational scientific theory has been assimilated entirely to the humanistic libertarian approach because of the symbol assigned to it. This is *not* to say that it is *not* a humanistic program. It most certainly is. Indeed, it is humanism at its best since it combines the libertarian tenderness toward the individual's suffering with intelligence, persistence and courage —courage which is a high disciplinarian virtue. But it is something else as well, and it should not be given a monolithic label which may endanger it when public sentiment changes.

You may feel that we have been placing undue emphasis upon this point. After all, in recent years we have had a libertarian climate and it is natural that the symbol of progress should be a libertarian one; it is even advantageous to have it so. Our concern is, however, that the great complexity of the problems that we deal with should not be lost or obscured by the use of slogans. In this particular issue, whether the doors are open or whether they are locked can become a moral issue and doctors and hospitals can be judged as good or bad depending upon whether or not they subscribe to this particular policy. Just as once it was possible to keep patients herded within a dayroom and trained not to cross the doorway leading to the hall even when they were unattended, so it is quite possible that we can have open doors without an accompanying therapeutic program. Such a practice, which is perfectly possible, could make a mockery of our intentions. If there is continuing emphasis on the symbols only we can expect to see hospitals complying with public demands and giving them only the window dressing. This could result in the discrediting of the programs for which these symbols have come to stand. Then if the pendulum swings and the public mood changes we shall have difficulty not only in defending our symbols but in defending the programs they represent. Crusades must always, of course, have flags, and causes will always generate slogans, but this is no excuse for our becoming confused. It is important that the mentally ill be treated humanely. It is just as important that they be helped to get well. We must not let the success of new methods blind us to why they work.

One last example of what we mean will be sufficient. A few years ago a program for regressed patients on the poorer wards of a large hospital was being developed. The program was carried out in groups from 8 to 10 patients in which strong group identity was encouraged and in which group processes were utilized as therapeutic tools. As individual patients improved, doctors and ward supervisors were delighted. They felt that as soon as a patient had recovered to the place where he could function efficiently on a better ward, he should be moved to such a ward. One of us, the planner,[18] opposed this view because we knew that breaking up the groups would destroy the very therapeutic process which we had put into effect. We felt it wiser to hold the groups intact until the patients had improved to the place where they could all be moved together to better surroundings. There was, at the time, some criticism of the heartlessness of our approach. But this was not really the point. Neither we nor the critics were heartless; we simply had different degrees of sophistication about the means to the end we both held, namely, the recovery of the patient. And the reason we did not agree was because the planner

[18] John Cumming.

was focused upon the dynamics of social recovery in the group situation and the others were focused upon the traditional *symbol* of individual improvement, that is, removal to a better ward.

The point, in summary, is this: *we must know what we are doing as well as why we are doing it.* We can, by being rational and analytical in our mental habits as well as humanitarian and libertarian in our moral posture, establish our work on such firm foundations that if public attitudes swing to a more disciplinarian mood our policies and methods of treatment will remain acceptable. They will be acceptable not only because they are humanitarian but because they work and therefore serve both society and the individual best by being the most efficient means of dealing with the social problem of deviance as well as the individual tragedy of illness. If we are to achieve our ends we must combine not only the libertarian ideal of humanism and the disciplinarian ideal of courage, but we must add to these a thoughtful rational habit so that our work will be valuable no matter what the temper of public opinion. In this way we shall not lose—as we must not lose—the tremendous advances we have made in the last few years.

WILLIAM MALAMUD, M. D.

Research in mental health

Results obtained and plans for the future

On November 8 and 9, 1958 the committee in charge of the research program sponsored by the Supreme Council of the Scottish Rite in cooperation with the National Association for Mental Health held its annual meeting at which chief scientists of research projects in this program reported on the results of their work during the last year and on their plans for future investigations. This is a biennial event which was started some years ago. Its purpose is two-fold: First, to provide the committee with information that can be used in evaluating the progress of the projects; secondly, and more important, to give all the research workers an opportunity to learn what the others are doing in their special fields. In this way each is enabled to see how his particular work fits into the general program and how he could apply some of the methods used by the other scientists to his own project, and thus broaden the scope of his investigations.

In most respects this meeting was similar to the ones held previously, but this year there were two significant new developments:

- The title of the program was changed from research in dementia praecox to research in schizophrenia.
- During this last year plans were formulated for the organization of a comprehensive program of research in the general

Dr. Malamud is directing the expansion of the research program carried on by the National Association for Mental Health. This paper is based on a report he presented November 19, 1958 in Kansas City, Mo., at the organization's 8th annual meeting.

field of mental health to be supported by the National Association for Mental Health in addition to its participation in the sponsorship of the more specific program of basic research in schizophrenia.

These two developments are so intimately related to one another and to the progress of research in this field that it seemed most appropriate to use them as the pivotal point in this article.

THE CHANGE IN TITLE

At its last executive meeting, the Scottish Rite committee, after due deliberation, decided to change the title of the program which it sponsored from research in dementia praecox to research in schizophrenia. True, usually a change in name does not necessarily imply an important change in content. In this case, however, the change was highly significant. The term, dementia praecox, under which this disease was first described 100 years ago, literally meant "mental deterioration (dementia) such as is observed in cases of advanced senility, but occurring in adolescents or very young adults; in other words, at an unripe age (praecox)." This precocious deterioration, furthermore, was considered by Morel, who first described this disease as due primarily to a pathological heredity, as an inevitable fate which these unfortunates brought into the world with them from their ancestral background. Burdened by this inheritance and doomed to an incurable disease, these persons, as he saw them, were left without any hope for prevention before the disease became manifest and nothing one could do to treat the illness after its beginning. This hopeless attitude towards the disease, which was soon found to be highly frequent in increasing numbers of young people, continued for many years and obviously stifled any attempts to search for its causes and thus to develop methods of prevention and treatment.

The name, schizophrenia, however, was proposed by Bleuler to indicate, as the term implies, a "splitting of the mind or personality." It differed from the old connotation by introducing the idea of a disease process which developed during the lifetime of the afflicted individual and which largely depended upon injurious experiences to which he had been exposed. It meant that although certain vulnerabilities to stressful experiences may be inherited, a person who had these vulnerabilities would not of necessity develop the disease, but would become a victim only if a large number of injurious events took place during his life. Furthermore, the new term implied that the outcome was not an inevitable deterioration, but that, if the effects of these experiences could be counteracted by suitable methods of treatment, one would be justified in expecting improvement or recovery. In other words, introduction of the new name and, what is more important, the idea behind it, brought with them the hope for possibilities of both prevention before the onset of the disease and treatment once it started.

It is true that 50 years ago when the new name *schizophrenia* was first introduced, it was based mostly on theoretical considerations with very little valid scientific proof available to support it. This was true even 25 years later when the Supreme Council of the Scottish Rite initiated the program of research in this illness. Most probably because of this (although the name *schizophrenia* already existed at that time), the committee still maintained the name of dementia praecox, presumably until such time as its research work brought results which could provide a solid foundation for considering this a disease process produced

by causes similar to those of other diseases and therefore subject to the same type of basic research as any other medical disease.

This long-term realistic attitude also expressed itself in the nature of the research that the Supreme Council, on the advice of its committee, undertook to sponsor. It was not a search for a quick remedy, but a slow and systematic study of the basic biological, social and psychological sciences of human behavior which would lead us to a better understanding of the disease and a rational formulation of how to deal with it. Actually, it was not until very recently that we began to see the importance of the discoveries made in this research work and the possibility of gaining an insight into the nature of the disease and the manner in which it can be combatted. Thus it was only this last year that the committee felt justified to substitute the name *schizophrenia* for *dementia praecox*.

During the period covered by the reports presented at the meeting last November, 26 projects were supported, each dealing with original research in various basic sciences of human behavior. They include studies in biochemistry, physiology, endocrinology, genetics, neuropathology, psychology and sociology. In addition to supporting original research of this type conducted by scientists of national and international reputation in their particular fields, funds were allocated for eight stipends to support young students who have shown interest in and aptitude for research of this type, for the purpose of training them as future workers in this field. Many of these projects have been carried on for years. Others have just recently been started. Each of them covers its own technical field in such a comprehensive way that it would be both impossible and not particularly desirable here to go into their technical details. It would be well, however, to describe briefly some of the studies, particularly those which demonstrate with special clarity that we are dealing with a disease process rather than an hereditary curse, and that with a more adequate knowledge of its causes and manner of development we will be able to devise better treatment and a systematic program of prevention.

One of the research areas which has been particularly indicative of the active, process-like nature of schizophrenia and which has brought especially promising results within the last few years is the biochemical changes occurring in this disease. As an example of this we have in the Illinois Neuropsychiatric Institute a project which deals with derivatives of chemical substances produced in human beings which, given in large quantities to animals, produce marked pathological changes in their behavior. Furthermore, it has been reported by other workers that these derivatives, given to normal individuals for brief periods of time, produce temporary mental changes resembling schizophrenia. This experimental production of "models" or "imitations" of mental disease has been successfully achieved in the past through the use of a number of drugs derived from plants. Now, however, the fact that more or less similar effects can be produced by substances found in the body brings up the possibility that the production of abnormally large quantities of these substances in human beings in certain stress situations may be associated with the development of mental disease.

The same research workers have also found that certain drugs, which they have produced synthetically, are effective in counteracting some symptoms of mental disease and of preventing the development of these symptoms if used before the administration of the toxic substances. This, of course, introduces important implications for the fu-

ture, in that a more adequate knowledge of the factors involved in the development of the disease may enable us to devise rational methods for treating the symptoms and preventing the disease.

A number of our research workers in other institutions are actively studying other aspects of this particular subject. In a large measure their findings lead to the same conclusions, with the added advantage of checking up on possible errors and with the assurance that the variety of methods used will make it possible to reach more reliable results than if it were done in only one laboratory.

Another group of projects which demonstrates particularly well the transition from the concept of a pathological state to that of an active process are those investigating the genetic-dynamic aspects of the disease. It is quite true that people who develop schizophrenia are most likely to have some constitutional weakness rendering them more vulnerable to certain types of injurious experiences than the average person would be. This being the case, it is most essential to find out, first of all, the nature of this weakness and whether it is due to some deficiency which could be compensated for, and secondly, to identify the experiences which are particularly likely to harm those endowed with such a vulnerability. During the last year our research workers have reported results which indicate that this constitutional vulnerability may be dependent upon a specific disturbance in the bodily defense mechanisms as they are represented in a variety of cellular protective functions. The study of this disturbance is now being carried forward very intensively by Dr. Kallmann. It is obvious that a positive identification of such a disturbance could serve as the basis for the development of a systematic preventive program. At the same time, our child psychiatrists and psychologists have been working very actively on identifying the nature of the experiences which are particularly likely to lead to the development of schizophrenia in vulnerable individuals. A number of important publications have come out from several institutions, particularly the Putnam Children's Center and the Judge Baker Guidance Center, indicating the nature of these injurious experiences and the manner in which an understanding of them can be put to use in the treatment of children who have developed schizophrenia and in the organization of preventive measures.

Closely related results have been reported by Dr. Whitehorn's group of research workers who undertook a series of studies on psychotherapeutic methods of treating these patients. They found that the treatment's efficacy depended largely on the type of relationship between the physician and the patient, as well as the particular steps that were employed in setting up this relation. In addition to this, these studies have further clarified the nature of the illness and the social and psychological factors that are in a large part responsible for its development.

A particularly important contribution to the understanding of the relationship between clinically and psychologically observed behavior abnormalities and relevant biochemical disturbances has been reported by research workers in one of the projects at the Lafayette Clinic in Detroit. They take their point of departure from the generally accepted fact that one of the most striking clinical observations in schizophrenia is the apparently lowered availability and mobilization of outwardly directed energy, particularly in response to stress. The patient seems either unable or unwilling to exert himself physically or emotionally to react adequately to stress situations as a

healthy person would. Figuratively speaking, he adopts a sort of "couldn't care less" attitude. At the same time it has also been found experimentally that the amount of energy available to a normal person and his readiness to mobilize it in response to stress is very closely tied up with the various stages of phosphorous metabolism. With this in mind, the researchers proceeded to compare the stages of phosphorous metabolism in schizophrenic patients with those of healthy persons when both were at rest and also when they were placed under identical types of stress situations. The results were clear: in response to stress the healthy person invariably showed a marked increase in phosphorous activity, whereas in the chronic schizophrenic there was no change or even a marked decrease.

"These findings," the scientists conclude, "suggest that in schizophrenia there is a basic disturbance in this energy supply. This disturbance appears to involve first a use of large amounts of energy in the chronic schizophrenic patient in a different manner than normal, and second a failure in the ability to apply energy effectively when needed. . . . It suggests the presence either of a substance which blocks the use of energy or an enzyme defect which prevents the normal flexibility in energy utilization."

A number of other studies—physiological, neuropathological, social and cultural —have helped in furthering our understanding of the particular types of disturbances that are produced both physically and psychologically in these patients, so that our ability to recognize or diagnose these cases at the earliest possible moment has been enhanced. At the same time we are also making progress, on the basis of such studies, in the effectiveness with which we can predict the eventual course of the illness. At the outset of this program 25 years ago, when all of the research was devoted primarily to the basic sciences, it may have seemed to many that there was very little relationship between the projects investigated and the disease, dementia praecox. As time went on it became quite obvious that with the coordination provided by the committee and the progress made by each investigator there had developed a gradual convergence of the program towards the common goal of trying to understand the disease in order to find reliable means of combatting it. The nearer we approached that stage the more important it became to consider very seriously two other activities that should be closely associated with a research program of this type. These were:

- As we continued to make progress in basic research, the technical knowledge necessary to study adequately each one of these basic sciences increased in scope and complexity. It became very important, therefore, to train scientists who would be adequately prepared for and genuinely interested in this subject, so as to carry on research of this type in the future. This meant that to strengthen our program while still continuing to support research by highly qualified original workers, we must recruit younger people who could become proficient in the specialized techniques provided by the more mature scientists and who could continue their investigations. Recognizing that need, the committee has developed a program of training students (mostly during the course of their medical studies) by offering them modest stipends for their summer vacations so that they will be in a position to utilize this time to work in the laboratories of some of our original research workers, get to understand the methods used in such work, and become interested in this area of research. At present eight stipends are being allocated to

students selected by prominent scientists in universities or medical schools, and we are looking towards an increase in this program so that as we extend our work we will also have a greater number of well-qualified persons to do it.

• At the same time it has become obvious that our research workers in the basic sciences are able to contribute more knowledge of the fundamental factors in the causation of this disease and that the possibility of applying this knowledge in a practical search for adequate methods of treatment has become more real. Thus it also became essential to enlist the aid of other workers or agencies who could be both willing and able to undertake the evaluation of the practical application of these results—whose research would lead to improved diagnostic and treatment methods, to the application of principles discovered by the research workers to public education, and to the improvement of conditions under which the adjustment of people who have been mentally sick or who are susceptible to mental illness can be maintained at an adequate level. Similar needs emerged for the establishment of programs of readjustment or rehabilitation of those patients who have been treated but in whom some defect may have been left by the disease which prevents them from returning to their previous manner of living.

It is fortunate indeed that the original organization of this program was implemented by the Supreme Council of the Scottish Rite in close cooperation with and with the professional guidance of what was then known as the National Committee for Mental Hygiene, one of the predecessors of the National Association for Mental Health. The latter, like its predecessors, has continued to maintain as one of its main goals the practical application of this type of knowledge gained through research in the basic sciences. It is therefore very gratifying to find that during the last year the National Association for Mental Health has decided to establish a research program which, while reaching out for a broader scope of problems to be investigated, will complement and supplement the one sponsored by the Scottish Rite. This is obviously a natural sequence to the cooperation between these two agencies over these many years. It will make it possible to utilize all of the work that has been done in the past and that will be continued in the future by the research workers in the Scottish Rite program in dealing with the more comprehensive activities of the NAMH.

To assure adequate cooperation and mutual help in carrying on both of these programs it was agreed by both agencies that the research director of the Scottish Rite program will also be the director of the NAMH research department. It was understood, however, that the Scottish Rite program of basic research in schizophrenia will maintain its independent and unique role as it has during the 25 years of its existence; that it will continue the pioneering exploration of the fundamentals of the nature and causes of this illness; that the committee on schizophrenia will maintain its present composition and functions specifically devoted to this program; and that the director of research will continue to devote the same amount of time and effort to the coordination and direction of this program as he has until now. Insofar as the program of the National Association for Mental Health is concerned, the research director will devote to it the time he has hitherto given to teaching, clinical and research activities as chairman of the division of psychiatry at Boston University's medical school.

The NAMH research committee consists of some of the most prominent representatives of the broad spectrum of scientific and professional disciplines relevant to the field of mental health. They have the skill and judgment essential in the practical administration of such a program. This committee will be responsible for evaluating and selecting the projects and programs to be supported, establishing policies for the research department and advising and guiding the director and his staff.

The formulation of a well-defined and systematic program will be undertaken by the research committee as one of its first functions. The general outline of the fundamental principles of the program, however, as it was presented originally to the board of directors of the National Association for Mental Health and discussed with some of the members of the committee in a preliminary way can be described as follows:

A major function of the program will be the adequate support of scientific investigations of all areas relevant to the fight against mental illness and the promotion of mental health. This support should consist not only of necessary financial help but also of essential information and technical advice whenever requested by the applicants. The scope and nature of the research to be supported, in keeping with the general objectives of the program of the National Association for Mental Health, will include all the phases of human behavior and adjustment in health and illness. In this regard we are especially fortunate in that the inauguration of this work will have as a background the pioneer work that has been carried on for 25 years and will be continued by the Scottish Rite program. True, this work concentrated primarily on basic research in schizophrenia, but this disease occupies a unique position in the field of mental illness. It is not only the most prevalent of these illnesses, but it affects human beings in such a comprehensive fashion that anything we learn about the nature and causes of schizophrenia can be used in studying all other personality disturbances. The results reported above, therefore, can serve as an excellent starting point in the broader program we are now entering. It is also important to emphasize that although we are planning to continue active support of investigations in the basic sciences we will also encourage and assist those who are engaged in fact-finding and epidemiological studies and investigations dealing with the application of the results of basic research to the practical phases of treatment, prevention and rehabilitation.

As the potentialities and needs for expanding the investigations develop both in scope and complexity, they bring with them a progressively increasing need for personnel. This means that along with supporting research in progress we will also have to concentrate on recruiting and training persons who will be well-qualified to join in this work and continue it in the future.

As we survey the present status of research in mental health throughout the country we find that to get a true picture of both needs and potentialities it is necessary to go beyond published material or reports presented at meetings. Very frequently we find, in institutions for the mentally ill or in community clinics, highly promising prospects and valuable material that have not been utilized. Sometimes this is due to exaggerated modesty or lack of suitable contacts for persons who have the potentialities for research; in other places it may be the result of poor facilities for such work. At the same time it is important to realize that such a program as we propose to establish, if it is to result in

fundamental knowledge that transcends regional and cultural superimpositions, will have to represent a wide variety of local characteristics, both as to particular needs and as to specific ways in which problems must be handled. Because of this it is proposed that this program should not limit itself to the support of research entirely on the basis of incoming applications, but that we should also go out and search for possibilities, stimulating, encouraging or acting as consultants wherever this is desired or actually sought for by local workers.

It is quite obvious that a program of this type, carried out within the framework of the general plans of the National Association for Mental Health, can succeed only if it is given the wholehearted support of the entire membership and all the state and local mental health associations. This is necessary not only because they are the source of financial support, but because universal representation of all parts of the country will definitely assure validity of results and the highest success in applying them to practical needs. Given such support and the high quality of scientific competence represented by the committee, I have no doubt that this program will assume the position of leadership in mental health research that rightfully belongs to this association.

PETER E. SIFNEOS, M. D.

Preventive psychiatric work with mothers

Ordinary people do not usually visit a psychiatrist. If they have emotional problems they hesitate to communicate them even to their close friends and try to deal with them on their own. Access, therefore, to such individuals and assessment of their emotional problems is difficult. On the other hand, one is usually impressed by statements of emotionally disturbed individuals about the times when they felt well. They invariably refer to missed opportunities to solve past emotional problems, or to lack of knowledge about whom they could have turned to at such times. They also acknowledge that psychiatric help might have prevented their present difficulty.

An attempt to describe preventive psychiatric work with emotionally stable young mothers who had a disturbed relationship with one of their children will be briefly discussed in this paper.

Over a period of two years 50 young mothers came to the Human Relations Service of Wellesley, Mass., a community mental health agency in a Boston suburb, to talk about the emotional problems of one of their children. Usually aggressive or excessively docile behavior of the child at school or in the home constituted the majority of these problems.

The mothers came to the agency on their own or were referred by their family physician, their minister or a school teacher. School teachers referred 17, physicians 7,

Dr. Sifneos directs the psychiatric clinic at Massachusetts General Hospital and is an associate in the department of psychiatry of Harvard Medical School.

ministers 3 and the rest came on their own initiative.

When first seen by the psychiatrist most of the mothers appeared to be somewhat anxious and tense; others felt guilty. They said they knew something was wrong and they sensed that in some way they were involved in their children's difficulties. A few denied any knowledge of difficulty at first, but by the end of the interview it had become apparent to them also that they were connected with the problems of their children. They were therefore willing to return for a second interview. It was usually quite apparent that the mother-child relationship was disturbed and that the mother or the child or both of them needed some help.

In some cases the disturbed behavior of the child generated anxiety and guilt in the mother, as well as indecision. A change or deterioration in her relation with the child and continuation of his disturbed behavior, either at home or in the school, led to a progressive inability to cope with the child's emotional problem. Being unable to deal with this situation and trying to punish the child increased the mother's anxiety. This in turn further aggravated the disturbed behavior of the child. It was soon obvious that a vicious circle was formed that radiated distress to the whole family. The talk with the minister, physician or teacher and referral of the child and his mother to a community mental health agency intensified further the mother's awareness of her emotional difficulties. It was because of these feelings that the mothers were easily motivated to work with the psychiatrist.

Three approaches were usually considered after the mother and the child had been interviewed by an adult and a child psychiatrist respectively. First, if it appeared that the child and the mother were severely disturbed they were both referred for psychiatric treatment. This occurred on only one occasion. Second, in two cases the child treated by a child psychiatrist and the mother was seen by a social worker. Third, with all the 47 remaining mothers it was thought that the disturbance or emotional problem of the child was mild, but that it had the potentiality of becoming serious if the mother was not seen briefly by the adult psychiatrist for guidance. An attempt was therefore made to intervene to prevent future complications.

Most of the mothers were young, ranging in age from the middle twenties to the late thirties. They were intelligent, cooperative women without overt psychiatric symptoms or serious character disorders. They were essentially healthy "normal" women.

A systematic attempt was made in subsequent interviews to help each mother understand some of the underlying emotional conflicts in her child and quickly motivate her to view her own actions as possibly contributing to his disturbed behavior. This was in most situations achieved quickly—that is, in four or five interviews spaced over a few weeks to not longer than three months. During this time the child was observed closely by the teacher at school or by his family physician. They both communicated occasionally with the mother's psychiatrist. In some cases the child was directly observed by the psychiatrist in the school setting.

Usually in a short time there was a change for the better in the child's behavior. It was observable by the teacher and the mother as well as by the other members of the immediate family. The most striking change occurred in kindergarten, first grade children or young adolescents. Out of the 50 children involved, 14 were in the age group 5–6 and 15 in the age group 12–14, a total of 29. Disturbances and problems

in these two critical periods in a child's emotional development turned out to be the most common hazardous situations faced by the mothers who came to the community mental health agency.

The following cases are illustrative:

The mother of a 6-year-old boy was referred to the mental health agency by his teacher because of "unusually docile behavior at school," withdrawal from other children, tenseness and constant biting of his fingernails; in direct contrast was his behavior at home, where he was aggressive both against his mother and his siblings. The boy was the oldest of three children. He had essentially a normal development. There were no feeding problems. He walked and talked normally and was toilet-trained by the end of the 18th month. He did not seem to be disturbed by the birth of his siblings. He was in good physical health.

According to the mother, he became very dependent on her when he was 5 years old and began reacting with unusual fury when she would not give in to his demands. She emphasized that she had always had a strong desire to be "independent" and added, "I also teach my children to be independent." Both she and her husband had put pressure on the oldest boy to do good work at school. He worked hard and they praised him, but his ferocity when his demands were not satisfied by his mother seemed to continue unabated. The boy spoke often about violent deaths and on one occasion he hit one of his brothers on the head, causing some bleeding. On that occasion he was punished severely by his mother, and following this he had a temper tantrum.

The boy was interviewed by the child psychiatrist, who felt that although appearing somewhat shy he seemed to be a fairly normal child with no serious emotional disturbance. He was also observed by the psychiatrist on two occasions at school. There he did not partake in the discussion and did not communicate with the other children during the study hour. When asked questions, however, he always came out with the correct answer and seemed to be interested and alert during the times when the teacher paid attention to him. During recess he would run, or rather gallop, aimlessly alone all over the playground until, finally exhausted, he would sit down by himself.

The father was also interviewed at the agency. He drew essentially the same picture of the boy as the mother had done, and emphasized that his wife had great expectations for their son and pushed him intensively to achieve success.

The mother was 31 years old. She too was the oldest of four girls. Her father, an excessive drinker, was unable to support the family, and her mother had had to work. At a very early age the mother was given the responsibility of running the household and bringing up her sisters. She resented these responsibilities bitterly but, a perfectionist, she met them well. Willing and capable, she could not go to college. After she had married young and "successfully," she ran her family, including her husband, with an iron hand.

She was seen six times over a period of three months. The main focus of the interviews was the "problem of her son."

At first she was hesitant to give information about herself: "After all, I came here to talk about my son's problems." She soon relaxed, however, and discussed her life fully and easily. She described her anger against her father, and her subsequent guilt, with much emotion. She also talked about her mixed feelings for her mother. When she realized she was treat-

ing her son in the manner her parents had treated her—a manner she had thought very unfair—she became less demanding of him. Having talked freely about her hostile feelings for her sisters, she was able to realize her oldest son might have hidden hostility and jealousy for his own younger siblings. She could see how by being negativistic towards her when she failed to gratify his wishes he was expressing his need for rebellion. She quickly became more understanding. She gave the boy special privileges as "the oldest child," and a "special time" was also allocated to him to be with his mother. She did this without hesitation. As time went by her anxiety subsided. She was more tolerant of her son and more at ease with him. After she visited her own parents for the first time in six years she announced with pride that she felt little tension with them, something that had never happened to her before. The boy responded to this change in his mother very rapidly. His aggressive behavior at home practically disappeared, and he became more cooperative. He again started to play with his siblings and with other boys in the neighborhood without getting into fights. At school he was less tense, less withdrawn.

As the mother became more self-confident she began talking about how much she enjoyed her son's improved behavior, and added that "now I am able to understand his problems."

In three months a report from the school teacher stated that the boy had had a transformation: "He was much more relaxed, he played with the other children, and he did not bite his fingernails." The father also reported "good behavior" on the part of his son. It was decided then that the interviews with the mother should end. She seemed to be happy and felt that she had more insight into her own problems and into her son's difficulty.

A 5-year-old boy and his mother were referred to the mental health agency by the pediatrician because of the boy's fear of being injured. The child psychiatrist who saw the boy decided that no therapy was necessary at the time but thought that he should be seen occasionally, because it was possible that if his phobia did not clear up he might require treatment in the future.

The mother was seen six times over a period of two months. She gave the following history: This was her first child. She had been unhappy about her pregnancy and had had a difficult delivery. The baby had had no feeding problems. He had walked and talked normally, and was toilet-trained by the age of two and a half years. He had had the usual childhood diseases and had developed quite normally up to about six months before her referral to the agency. At that time, while playing on the beach, he saw a friend of his who had broken his leg and was wearing a cast. He seemed to be unusually interested in his friend's misfortune. He was told by his mother "when one misbehaves sometimes one falls down and breaks one's leg." He seemed to pay little attention to this statement. Five months later, while he was playing in the yard, the ball that he was playing with rolled outside the fence. As he ran to catch it a car sped by. His mother, who was running after him, was very upset and gave him a "spanking." She told him that he should be careful because the car could have "cut off his leg." Following this the boy became very upset, was unable to sleep, had occasional nightmares, and asked for constant reassurance from his mother about losing his leg or being injured. The mother grew alarmed and took him to

their pediatrician, who referred them both to the mental health agency.

The mother was 35 years old. An only child, she had been brought up by two rigid parents who had been divorced when she was 12. From then on she lived with her father, whom she described as very "sadistic" and who when under the influence of alcohol enjoyed taking her clothes off or slapping her repeatedly on the face. After she was graduated from high school she worked as a secretary for 12 years under a very "strong man." She met her husband, a somewhat passive individual, and married him. She was dissatisfied with married life. She always had ambitions of going back to work. Unhappy as a housewife, she tried to adjust by taking meticulous care of her son and her household. She admitted being at times very angry and domineering with her son.

In the interview she related fairly well but had a tendency to try to dominate the interviewer. She was quite intelligent and was willing to question the role she had played in precipitating her son's phobia. When it was explained to her that at some period of emotional development boys seem to become quite attached to their mothers she showed interest and mentioned that her son had been quite attached to her over the last year. She said that on occasions she had been quite embarrassed by his affectionate caresses and realized that her threats of punishment were due in part to her own uneasiness about this. She thought she might have been a little too harsh with the boy. She soon was able to see that her hostility and resentment of her father's domination had something to do with her trying to dominate her own husband and child. In the third interview she reported she had tried to be more lenient and had stopped her threats, and seemed to respond to her son's playfulness by being more relaxed.

In the last interview, two months later, she reported that the boy had not had any disturbing dreams, had stopped complaining about his phobic symptoms and now did not seek constant reassurance. She said she was encouraged. One year later, when her son was in the first grade, she reported he seemed to be quite relaxed and had made friends at school. His phobias had not returned. She was pleased with his progress and felt she had contributed to it.

A 50-year-old mother was referred by her minister because she was somewhat depressed and very tense over the overt rebellion of her 14-year-old daughter. The daughter had repeatedly defied her mother and had announced to her in the middle of the school year that she was leaving school and was going to stay home and do whatever she pleased. The more the mother pleaded with her the more defiant the girl became. It was quite obvious that in their past relationship the mother had been quite ineffectual in her discipline over the years. Despite having made attempts in the past to "draw the line" she had been unsuccessful. She said that her husband was of no help to her and that their relationship was poor. He had always taken her daughter's part in the past arguments. When the girl had announced that she was going to stop going to school, her husband had laughed and turning to her had said, "Now what are you going to do about this?" At the same time she related that otherwise she and her daughter had a good relationship and that difficulties had resulted only when she attempted unsuccessfully to discipline or punish her.

The mother was seen on five occasions over a period of three months, and an at-

tempt was made to give her some insight into her present involvement with her daughter. It was pointed out that the girl's defiance and rebellion were part of the adolescent's need for independence, and that the more the mother was involved with it the greater her chances of failing. She decided to pay little attention to her daughter and allow her to do whatever she pleased. She announced this both to her husband and to the girl, but for some time it was difficult for her to carry it through and to disengage herself from her involvement in her daughter's problem. For example, when her daughter went off to study and hinted that she might return to school, the mother became very pleased and encouraged her to do so. As time passed, however, nothing seemed to happen. It was pointed out to the mother that although it was understandable that she would wish for her daughter's return to school the quickest way to achieve this would be by helping the girl realize her mother had meant what she said when she announced she would not be involved in that situation.

She finally managed to make herself stand on the sidelines and watch what developed. It was soon apparent that her daughter had become tired of her lonely existence in the house, and she announced she might try to go back to school temporarily. Her mother made no comment. After the girl returned to school, realized she had missed much valuable time and was faced with the possibility of having to repeat the same grade, she became alarmed and rushed to her mother for forgiveness and help in making up her lessons. The mother returned to the agency and announced she was delighted by this turn of events. She said she declined the request to help the girl with her studies. She added that she now understood adolescent behavior a little better. She also said she had learned something about "drawing the lines" and was not so intimately involved with her child so as to threaten her attempts for independence.

Most of the other cases worked out similarly. A child was helped when his mother was helped.

Ten mothers returned to the agency subsequently seeking guidance about emotional problems in other members of their family, claiming that they had been helped before. There were no recurrent difficulties in the children involved except in one case—a phobia recurred in a girl 7 years old. This child was referred for private psychotherapy.

DISCUSSION

The mother-child relationship is subtle and changeable. It is as durable as the human beings involved. For the young child the mother's influence, beneficient or malignant, is overwhelming. An outsider wishing to help the child will often find the mother an effective medium. She may be more rigid in her character structure than the child, but she is also more easily available, more reasonable and more capable of controlling the child's intellectual, emotional and physical environment.

A disturbed mother-child relationship may go on undetected by the mother over long periods of time. It may require the overt disturbed behavior of the child to bring it into focus and give rise to anxiety in the mother. This in turn may create complications for her as well as difficulties in the emotional development of the child.

Psychiatric intervention at such a time may help the mother return to her previous psychological equilibrium, improve her relationship with her child, and avoid future emotional difficulties for both. It is im-

portant, therefore, that physicians, teachers and mental health workers recognize early emotional difficulties in individuals and refer them to psychiatrists, mental health agencies or child guidance clinics for appropriate help.

SUMMARY AND CONCLUSION

This is a brief report of psychiatric work with 50 mothers who had disturbed relationships with their children at a critical time in the child's emotional development. Three cases are presented to illustrate how brief psychiatric work with the mother may improve the mother-child relationship.

It is thought that such an approach may drastically change for the better the disturbed behavior of the child, may be beneficial to his emotional development, and may possibly help him avoid future emotional complications.

ACKNOWLEDGMENTS

The author wishes to express his thanks to Dr. Erich Lindemann for his helpful suggestions and constructive criticism.

Part of this work was supported by the Grant Foundation.

KATHERINE W. DUNLAP, M.S.W.

Some observations on acute learning difficulties at the college level

Almost every kind of emotional adjustment problem is seen in a college mental health clinic. None, however, can be more puzzling dynamically at times or more challenging to the therapist than those involving difficulties in learning.

A 17-year-old all-A high school graduate of great promise comes to the clinic, sent by the scholarship committee because he insists after the first few weeks in school that he is incapable of doing college work and is determined to withdraw. A senior, an honor student for three and a half years, abruptly loses interest in her goals, becomes withdrawn and is unable to attend classes. A graduate student comes in because he is unable to begin work on a thesis necessary to complete his degree. A potential engineer is panicky because he has repeatedly failed a required course though he has no difficulty in other studies. Such situations as these, and instances of inability to study, or concentrate, or pass examinations are familiar to every mental health clinic. Parents are distressed; advisers and administrators are frequently puzzled; and the students themselves are often bewildered.

What happens to capable students that they become, at various times in their college careers, unable to function academically?

We know that in some instances a realistic life situation of acute emotional stress, such as a broken engagement, a serious illness or death in the family or a pressing

Mrs. Dunlap is a mental hygiene counselor in the student health service of Wayne State University, Detroit.

personal problem, so absorbs all the individual's attention that a temporary withdrawal of psychic energy from the intellectual process occurs, and the student then finds himself unable to concentrate or to remember. This type of learning difficulty is familiar and usually is alleviated by supportive treatment.

But there are other instances in which a learning situation, under certain stress, may become attached to a repressed conflict. Then the acquisition of higher knowledge in general, or knowledge of certain content, a particular educator, the writing of an examination or the attainment of a degree may take on the significance of an unconscious forbidden libidinal activity or the meaning of an unconscious aggressive destructive accomplishment. The learning situation then produces an unbearable anxiety against which the student defends himself by an inhibition.

The inhibition may be an acute, isolated reaction in a relatively healthy personality or it may be only one of many chronic manifestations in a total neurosis or character disorder. It is the acute reaction which responds most readily to the type of brief psychotherapy available in most college clinics.

The following histories have been chosen to illustrate this type of inhibition. The student in each case was of good intellectual capacity, had made a satisfactory school and learning adjustment prior to the difficulty, and responded favorably to treatment.

Mary, a 19-year-old sophomore who had done good work her first year in college, came to the clinic at mid-semester for help, she said, in making a decision. She had already withdrawn from three of her classes and thought now that she should drop out of school entirely, take a course in typing and shorthand and go to work to help her family, whom she felt to be in financial difficulties. She said that her father's theater had been struck by a cyclone in the summer and she felt she should not ask him for school money any longer. She felt that worry over money might aggravate his high blood pressure. She said that her mother also had not been well since hospitalization four years ago following an automobile accident, and added that there was a 16-year-old brother also to be educated.

Further inquiry into the current situation revealed that Mary had missed the first three weeks of school because of an appendectomy; a few weeks previous to that her closest girl friend had died suddenly of an unsuspected cancer; and most recently the first boy she had ever been serious about had jilted her. Mary verbalized freely and easily, and in a couple of interviews the dynamics of the difficulty appeared fairly clear. As the result of a series of emotional stresses, which for Mary had been overwhelming, old infantile fantasies of a destructive nature, previously quiescent, had become reactivated and she was unconsciously experiencing being in college as a destructive activity: impoverishing her father, depriving her brother, making her mother more ill. Withdrawal from school now and the determination to "help" her parents was again, as at age 15, her defense against the guilt and anxiety she was experiencing.

Mary was seen once a week for the rest of the semester. She was helped to see how the hospitalization and death of her girl friend had reminded her of the hospitalization of her mother four years previously, and how this had stirred up the feelings of fear she had had then that her mother might die, and the guilt she had felt because of sometimes inconsiderate and hos-

tile feelings toward her.[1] It was also pointed out to Mary that she was attempting to handle her feelings now in the same way she did four years ago when she stayed home from school to "help" the family; and that while at that time her action might have been realistic, the situation now was entirely different. She was helped to see that in reality her mother was in good health at this time; that her father's financial situation was a very secure one; and that there were better ways of handling her feelings than dropping out of school.

This student developed a strong positive mother relationship to the therapist. With reassurance and encouragement she was able to relive a traumatic and threatening experience and to work through enough of her ambivalent feeling (which included resentful and revengeful feelings against the faithless boy friend also) and gain sufficient insight to enable her to remain in school. Her transcript for the last two semesters shows that she has been able also to return to her former level of school functioning.

The case just described and the two that follow illustrate, among other things, the importance of examining carefully the social setting in which the student is failing and the events just preceding the difficulty. This frequently not only gives a clue to the conflict being defended against but indicates as well how the school situation is being used as a vehicle for its expression.

Tony, a 22-year-old boy of Italian descent, came to the clinic near the end of his junior year asking permission to drop his Italian course for "health reasons." He was a rather passive boy, working his way through college and doing better than average work. He said the instructor "had it in for him." Tony said he felt extremely anxious in the presence of the instructor, was unable to recite or pass examinations, and had been unable to attend the last two meetings of the class. He felt he was being singled out by the instructor for ridicule and punishment, although he could cite no particular instances of this. He said the instructor was a "very cutting man who could slice you flat."

Tony was seen for three consecutive interviews. He was encouraged to talk about his home life, his father and their relationship. He said that he had never gotten along with his father and that as a result of their conflict he had "renounced his inheritance" and left home before completing high school. In describing his father Tony used the same words and metaphorical language he had used earlier in describing the instructor. The transference to the instructor was so clear from the material that it was interpreted quite directly together with his repetition of the method of solution—namely, to renounce his inheritance (credit for the course) and leave the threatening father (the instructor). With this insight Tony was able to separate the mastering of Italian (his mother tongue) and the instructor from his old developmental conflict, and he no longer felt anxious in the class situation. He reported, subsequently, that he had been able to talk with the instructor, who had proved very willing to assist him with back work, and that he had passed the course satisfactorily. (This was later verified.) The insight was, of course, not of sufficient depth to produce any dynamic or structural change, but did serve in this situation to detach the learning activity from the original conflict so that the stu-

[1] The earlier repressed feelings and fantasies connected with the hospitalization of the mother when the brother was born, which were much deeper, were not dealt with at all.

dent could again perform realistically in the course.

George, a 26-year-old senior in the College of Liberal Arts, married, with a 5-year-old daughter, was sent to the clinic by his academic adviser. He was in a highly agitated state and had been doing a lot of acting out. He had become enraged at an English instructor and impulsively dropped the course because, he said, the instructor had accused him of using unnecessarily big words to make himself appear sophisticated. Now he found himself so anxious and upset that he was unable to take an important examination in a race relations course scheduled for the following day. The examination was part of the requirement for a fellowship award for which he had been recommended. An investigation into the current situation revealed that the night before George had had an argument with his father on race relations, during which the father had become quite excited, accused George of trying to win the argument by using big words and ended up by taunting him with "So you want your daughter to marry a Negro!" This infuriated George but he had been unable to express any of the anger toward his father directly. He spent considerable time in the interview, however, ventilating his feelings of frustration at not being able to convince his father and expressing bewilderment at his father's inability to accept any new ideas. His father's fondest wish, he said, was to have him do well in college.

It seemed clear in the first interview that this student, still in conflict with his father, was using the school situation as an instrument of rebellion and displaced anger and was confusing his English instructor with his father, and interracial relationships with the relationship between father and daughter. This was interpreted to George on the basis of the conscious material he presented.[2] He took the examination and received an A grade. On the basis of this and a paper he submitted later he was granted the award. At the end of the semester he reported he had had no further trouble. (His transcript showed three A's and a B.)

Many different types of pressures may act as reactivators of old conflicts. To the still immature 17- or 18-year-old, for whom college represents the final steps in a successful maturation, choosing a vocation or dating for marriage may stir up fantasies which are quite overwhelming. For example:

Joan, an 18-year-old second-semester freshman, was sent to the clinic by her academic adviser because at the mid-semester she was failing a history course for the second time. Joan said she was at a loss to understand why she was failing a subject in which she had received all A grades in high school and which was what she had intended teaching. She claimed she liked history and really knew the material but that on examinations her mind went blank and she could remember nothing. "Deep down," she said, "it seems I don't care if I fail—but I really do." Joan went on to say that she really did not want to come to college and was here because of her parents' insistence; that she was deeply in love and wished only to be married; and that her parents, especially her mother, did not approve of her boy friend—in fact, did not approve of marriage to anyone until she had finished her education. It developed that Joan had

[2] The unconscious identification of himself as a Negro and the incestuous implications for him in the father's accusation, "So you want your daughter to marry a Negro!" was of course not interpreted.

never discussed her feelings with her parents, knowing already, she said, what their reaction would be. Also, her boy friend had never actually proposed marriage, although they had gone together steadily for over a year and she felt marriage was logical and inevitable.

The therapist expressed the opinion that it was all right for Joan to drop out of college if this was what she wanted to do but that there were better ways of doing it than flunking out, and encouraged Joan first of all to have a talk with her parents. This she did. Much to her surprise, she found they were very understanding, quite approved of her boy friend, and didn't care whether she went to college or not. She also discussed the situation with her boy friend, who made it quite clear that although he was willing, at this point, to become engaged, he would not be in a position to marry for at least two years. Joan was very happy at the turn of events. Now that she wasn't being "forced to become a career girl," as she put it, she wasn't so anxious to leave school and felt sure she would have no further trouble with her history examinations. A week later she reported she had passed her examination with an A grade.

Joan was seen for only three interviews, but one can surmise from the turn of events that she was using the college setting for the acting out of a fantasy, projecting her own fears of marriage and independence. When she was confronted with reality, the purpose of the fantasy was destroyed, and she could then proceed with her college work. (She had had E at the mid-semester and ended the term with a C average, so she must have received an A on the semester examination also.)

Such inhibition as Joan's, commonly seen in first-year students, may not develop until the last semester of the senior year. Then, in still immature students, the pressure of graduation, with its unconscious meaning of accomplishment, produces an overwhelming anxiety.

Such was the case with Carol, a 22-year-old all-A student in the last semester of her senior year in the College of Education. She was sent to the clinic by her academic adviser because she had repeatedly failed to appear at her teaching assignment. When the adviser expressed concern and asked for an explanation Carol had become withdrawn and uncommunicative. The adviser was bewildered, as Carol had heretofore been one of the school's most dependable and promising students. Furthermore, the adviser was troubled because she felt the school had been put in an awkward position inasmuch as Carol had been accepted, upon the department's high recommendation, for an unusually good position in an eastern school.

To the therapist Carol stated that she liked her teaching supervisor, had no difficulty with the children, and was at a loss herself to explain her sudden lack of all enthusiasm for teaching, except that recently she had felt exhausted all the time and that her assignment further depressed her. It seemed to her now that getting a degree was unimportant and that she would be happier working at some job which made no intellectual demands on her. She knew this would make her parents happier also, as they felt college had made her feel superior and ashamed of them. This Carol at first denied. But as she explored her feelings she was able to admit that getting good grades, knowing things her parents could not understand, spending most of her time in school activities in which her parents could have no part had given her a certain amount of smug satisfaction. She was an adopted child. She deeply resented the fact that her foster parents

had tried to conceal from her her adoption at the age of four. They thought she was too young to remember. She had cooperated in the deception, although she remembered clearly her own mother and older brother and the traumatic circumstances of her abandonment by her mother —her sense of bewilderment and her feelings of anger and helplessness.

Here is a girl who had been able to picture herself as an adult, succeeding in school, preparing herself to take a job, leaving home and being quite independent of her family; but when she was faced with these ideas becoming realities the old unresolved fears of the abandoned little girl, angry, alone, helpless, were more than she could cope with. Further learning, graduation, the out-of-town job, along with the unresolved conflict, had to be defended against.

As in every instance the therapeutic task was to separate the school situation from the repressed conflict. In Carol's case this was accomplished partially by interpretation but largely through the relationship in which the therapist became to her the idealized, understanding, protective mother. Carol returned to her practice teaching, was graduated and accepted the job. She returned several times, however, within the next year to see the therapist and finally accepted a referral for further psychotherapy.

The treatment of learning inhibitions in college students, unlike other problems of emotional adjustment, is complicated by a time element. Results must usually be obtained in a relatively short time if the students' college experience is not to be interrupted. It is important, therefore, to evaluate as quickly as possible the nature of the inhibition and to determine whether or not short-term treatment seems feasible. Once this has been established and treatment undertaken a variety of insight-producing techniques may be used—clarification, education, use of relationship, interpretation of ego functioning, confrontation with reality, etc.—keeping in mind the therapeutic goal, which is merely to detach the learning situation from the underlying conflict and not to dissolve or make conscious the conflict itself. The effectiveness of any tehnique, however, presupposes two conditions: first, the spontaneous establishment of a positive relationship between the therapist and the student; second, a correct understanding of the individual dynamics involved—not for the purpose of interpreting back to the student, as is done in a deep reconstructive type of therapy, but to guide the therapist in using the relationship for the best interests of the student.

The nature of the relationship may be outside the therapist's control, especially in instances where the student has been sent to the clinic by an adviser or comes at the insistence of a parent. As to assessing the dynamics, we have at our disposal considerable technical and theoretical knowledge of the general dynamics of learning and of some of the emotional reasons for its interruption.[3] Our problem is how to apply this knowledge to the individual college student who comes to us. Obviously, no prolonged type of exploration is possible. Our speculation as to the meaning of the inhibition, the nature of the conflict defended against, and the personality of the particular student in which it occurs has to be based very largely upon our observation of him in the interview, our knowledge of his current functioning, and the conscious material he is able and willing to reveal about himself and his history.

[3] See references.

This type of therapy makes considerable demand on the therapist and not all cases are as successful as those chosen for presentation in this paper. We feel, however, that the college mental health clinic is the logical and appropriate setting in which to undertake this treatment. When it is successful it is a most rewarding service, both to the college and to the student. It merits further exploration.

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MARTIN L. KUNDIN, M.S.
LENORE M. SPORTSMAN, M.D.

A child guidance center's role in the evaluation and placement of infants in adoption

In 1951 the Albany Child Guidance Center and the Church Counseling Service of Albany launched a pilot study of pre-adoption infant evaluation and placement. Until this time the community agencies' practice was to delay placement until the child was "testable." The child, usually illegitimate, was superstitiously seen as a potential "bad seed" from which adoptive parents must be protected. Consequently, the infant was six months old or more before pre-placement study was attempted. The necessity of institutional or relatively long-range foster home placement in lieu of early adoption heightened the possibility of early emotional damage.[1]

In the initial phase of the project the center agreed to continue the current community practice and evaluate the infant at six months. As the community and placement agencies were able to accept and have confidence in our evaluation, we were quickly able to lower the age of evaluation and adoption to three months and then to one month. In the last two years we have tentatively moved into what we feel is the last step of the project—the occasional placement of infants into adoptive homes directly from the hospital. (This is done on a limited basis for reasons that

Mr. Kundin is the chief clinical psychologist and Dr. Sportsman the director of the Albany (N. Y.) Child Guidance Center for Psychiatric Services, which is affiliated with Albany Medical College.

1 Spitz, Rene A., "Hospitalism: An Inquiry into the Genesis of Psychiatric Conditions in Early Childhood," *Psychoanalytic Study of the Child.* New York, International Universities Press, 1945, I, 53–74.

will be discussed later in this paper.) Three weeks after placement we test these month-old babies for the first time.

The success of this project is currently reflected in the recent inclusion of other community infant placement agencies in our program. We now estimate that 95% or more of all infants placed through responsible local placement agencies are involved in the center's pre-adoption program. We have also received facetious complaints from these placement agencies that the surrounding counties are now sending their infants to our local agencies for placement because of our attractive placement practices. In a neighboring county a community placement agency has been putting pressure on their psychiatric facilities for a similar service.

METHOD

An infant surrendered for adoption is usually separated from his natural mother during his first week of life. He is then sent to a closely supervised boarding home or a medically directed infant institution, depending on the placement agency's policy. In either case when he is three weeks old an appointment is made with our center for the initial evaluation of the infant. A few days prior to evaluation he receives a complete medical examination by the placement agency's pediatrician. A summary that includes a complete birth and medical history, with additional observations by the social worker, precedes the child. Also included is the social history of both natural parents, indicating their educational level, socio-economic status and cultural background and the significant medical history of their families.

When he is a month old, the infant is brought to the center by the nurse or boarding parent, who accompanies him to the testing room. There the Gesell infant developmental scales[2] are administered by the psychologist, with the psychiatrist observing. Directly following the evaluation the psychiatrist, psychologist and placement agency's social worker discuss the findings and make suggestions regarding placement. The infant is usually placed in the adoptive home within a few days following the initial evaluation. The final decision on the selection of the appropriate adoptive home is always made by the placement agency.

After the infant has been in the adoptive home for a year and before final legal adoption procedures are carried out, the placement agency schedules the child for re-evaluation at the center. A social history on the adoptive family and the child's adjustment to his home is carefully scrutinized prior to re-evaluation. The social worker accompanies the adoptive family to the center, where the child is retested on the Cattell infant intelligence scale[3] by the psychologist, with the psychiatrist and adoptive parents observing. Directly following re-evaluation, the psychiatrist, psychologist and placement agency's social worker discuss the findings and make suggestions.

INITIAL EVALUATION

In evaluating infants, if one accepts the "test score" as a finite measure of development, one loses sight of the infant as a growing, striving, interacting entity. At one month a premature infant will usually test low; to predict that he will be slow in developing is rather ludicrous. Thus,

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[2] Gesell, Arnold and Catherine S. Amatruda, *Developmental Diagnosis.* New York, Paul B. Hoeber, 1949.

[3] Cattell, Psyche, *Measurement of Intelligence of Infants and Young Children.* New York, Psychological Corporation, 1940.

we use the Gesell developmental scale as a rather loose frame of reference and as a means of codifying our results.

Our experience has led us to add several items to the scale. These items are in two areas, namely, "strivings" and "frustration recovery."[4] We evaluate the child's recovery from frustration in the belief that the easier it is to comfort a frustrated infant the more stable is his physiologic and emotional development. It is also useful to see how the baby reacts to comforting by the foster mother and how he reacts to comforting by strangers, and to note any differences, especially because of their implications in the infant's initial method of adjusting to his adoptive mother.

Our measurement of strivings is the result of the following clinical observations. Three different boarding homes are used by the Church Counseling Service. Each of these homes rarely has more than one infant at a time, so that the baby gets a full share of mothering. The boarding-home mothers are carefully selected for their abilities with infants. As we became acquainted with these three women, we were struck with the remarkable differences among them. Mother A is the physical type. Bring her an infant and she immediately grabs it, cleans it, feeds it and loves it. When she walks or talks or sits, her body is in constant movement, legs crossing and uncrossing, hands gesturing, voice chattering. Her infants seem to reflect this constant movement; their arms swing, their legs churn and their bodies wiggle. Mother B is the soft reserved type. Bring her an infant and she lays it on the table. The family gathers around admiringly and radiates delight. When the baby is comfortable she will then clean and feed him. When she is at the center we listen very closely to her comments, since she makes no observations that haven't been well thought out and are highly pertinent. Her infants are "eye" babies. They are contented, quiet infants with eyes that reflect an amazing awareness; in a contented fashion they seem to absorb their environment and communicate through their eyes. Mother C falls between Mothers A and B and her babies seem behaviorally to fall between infants A and B.

It is our feeling that the ability of an infant to absorb and respond in kind to a specific type of handling reflects good mental health. Our experiences with infants from institutions where there is no consistent mother figure have led us to modify our concept of strivings to include the element of purposiveness. It is not that a specific infant is more prone to use his body or his limbs or his eyes, but it is our clinical impression that an infant who is able to utilize one of these modalities with purpose is demonstrating good mental health. Thus, an active infant who, stimulated with a rattle or the examiner's face, seems to focus his activities toward the stimulation, is considered to score high in strivings; a passive infant who, similarly stimulated, focuses directly on the stimulant and passively seems to be trying to reach out, is also scored high in strivings. One might well equate "strivings" with alertness. However, we feel that our method of trying to pinpoint the method of strivings may prove interesting in our planned follow-up study.

A factor that cuts across all items but has no scientific or objective measure is the feeling of comfort or discomfort which the infant precipitates in the psychologist and psychiatrist.

The premature infants present a special problem. If at all possible we insist on

[4] It should be noted that all infants are evaluated just prior to feeding time.

evaluating these infants at the usual age of one month. With them we are mainly interested in the "stabilizing factor." Since we find as a general rule that our "normal" infants achieve somewhere between the 4- and 8-week level on the Gesell scales and frequently perform items at the 8-week level, we are interested in the premature infant's ability to "mobilize" sporadically and be able, in part, to perform at "normal" level. However, most attention is paid to the infant's ability to be comforted and to relax. A crucial factor is whether he is hypertonic and to what degree. In the event he demonstrates some positive signs of stabilizing, immediate adoptive placement is recommended.

In our five years of experience in evaluating infants we have had two babies whom we diagnosed as deeply disturbed emotionally. Their behavior was similar; both were totally unresponsive limp "lumps." They had not yet been surrendered for adoption. One was brought to the center by his natural mother, a tense, deeply frightened, overactive woman from whom the baby had obviously withdrawn. We did not see the second mother but the reports suggested she had a similar type of personality. Fortunately, treatment was started immediately following both infants' evaluation. In each case our instructions to the placement agency were "Find a woman who has a deep love for babies and who will be able to keep this one in her arms until she can put him down and he falls into a natural relaxed sleep." The prescription was successful; in both cases it took two and a half to three days of constant care to break into the pattern of withdrawal.

We have had several instances of what we considered a mildly emotionally disturbed infant—the petulant, whiney, hard-to-comfort child with a tendency toward hypertonic or, more usually, limp reponses. In all cases this was clearly related to the occurrence of some specific traumatic event in the boarding mother's home—usually a death in the family. We have also noted a close relationship between the hypertonic infant and the amount of drugs used during the labor period.

THE CENTER'S ROLE WITH THE BOARDING PARENT AND NURSE

We insist that the boarding mother or nurse accompany the infant to the center. We are able to learn much from her about his behavior and development during his first month of life. She invariably compares him to other infants she has cared for. As we get to know these mothers well, we learn to spot areas of anxiety produced by the infant's behavior. During the 5-year acquaintance with the boarding parents, we form a good relationship and are able to involve them in discussing family problems that would have a bearing on their care of the infant. Parenthetically, we have been able to alert the placement agency when there seemed to be a need to stop using a specific boarding home temporarily.

With the nurses our approach is indirect. When we note that a baby is particularly responsive, we ask "Whose favorite is he?" "How did you know?" is the nurses's usual response. We then discuss generally the importance of paying attention and of talking to babies. Initially, most of the infants cared for by nurses were "the silent ones" with the usual baby sound conspicuously absent. The nurses' "talk" to these infants consisted of soothing clucking sound. It is most gratifying to notice the difference in the nurses' behavior now. They no longer "cluck" but speak quite spontaneously to the infants; the difference in the babies' language area currently reflects this.

Throughout these evaluations the psychologist and psychiatrist maintain a conversation designed to further the nurse's (or boarding-home mother's) understanding of the infant's behavior and needs.

INITIAL CONFERENCE

As was indicated, directly following the initial evaluation we discuss, with the referring placement agency's social worker, the test results, our observations and the baby's social-medical history. In most instances the placement agency has tentatively selected an adoptive home and several alternates. Our findings are "normal and ready for adoptive placement" for most infants. In the event we feel the infant deviates from the "normal" we define the type of family we feel will best meet his needs. In the deviate category, we consider four basic types: the anxious, the superior, the physically damaged, and the deeply disturbed. Our recommendations for the deeply disturbed infant have been discussed previously.

The anxious infant is tense and tends to over-react to stimuli. Startle reaction is prominent and of long duration. He will frequently fluctuate between bursts of activity and a hypertonic physiologic rigidity. His eyes frequently pop, the body frequently arches. One feels he is holding a rigid spring ready to uncoil. Again each case is individual. When the "anxiety" occurs in a premature infant and is felt to be a normal part of his stabilizing process, no special recommendations are made except to suggest that adoptive parents be calm. When the infant's anxiety is seen as being rather strong and sustained, the center may recommend that the infant be placed as a second child. We feel that a family which has had experience with one baby and has had the benefit of case work supervision will tend to be less anxious in handling a second child. The social worker is also alerted to the possibility of having to work more closely with this family during the initial adjustment of the infant.

The superior infant is defined as a month-old baby who demonstrates consistent achievement at a 2-month level or higher on the Gesell development scales. We recommend to the placement agency that he be placed in an adoptive home with stimulating parents who will not exploit his superior abilities if they continue to be manifested. Relatively young adoptive parents are usually sought. We are reminded of the first superior infant evaluated at the center; to the placement agency's social worker we communicated our findings and concern that he be placed in a "proper" adoptive home. A few months later the social worker requested consultation on the child. She expressed concern over the mother's obvious anxiety and overprotective behavior with the infant. In the conference the psychiatrist recognized that we at the center had communicated our anxiety about "proper" placement to the social worker and the social worker in turn had communicated this to the adoptive mother. Acting on this assumption the social worker was able to bring out the adoptive mother's fear that she had been given a defective baby and that the placement agency was hiding this fact from her. Subsequent re-evaluation, focused on alleviating the mother's anxieties, demonstrated a marked change in her attitude and a remarkable growth in the infant's capacities.

The physically damaged infant is not seen for evaluation at the center until a clear-cut medical diagnosis has been obtained. Studies of institutionalized children, as well as our own experience, indicate the need for placement outside a chil-

dren's institution with adoptive parents able to accept the damage. If the damage will lead to early death, or if there is permanent gross neurological damage, the baby is institutionalized. The center's role in the placement of physically damaged infants is to help the social worker understand the psychological implications of the infant's deficit and help anticipate the realistic difficulties the adoptive family may encounter. When institutionalization is indicated, the center's role is to support the placement agency's decision to institutionalize the infant and to deal with the placement agency's anxiety.

The need for the psychiatrist to recognize and deal with the social worker's anxieties over placement is crucial. It is for this reason that the last stage—direct placement from the hospital—has been cautiously approached. Our method has been to "stack the cards" by selecting infants with excellent family backgrounds. As the worth of this procedure has been demonstrated and the placement agency has become more secure in doing direct placement, the tendency has been to handle more placements by this method. The center's routine of examining the baby at one month and at one year does not change. The adopting parents rather than the boarding parent or nurse accompany the infant to the center.

It is well to note that despite a philosophy and policy of direct placement, there are many instances where this is not feasible. For example, the initial physical examination of the baby or the condition of the natural mother may suggest the need for a longer waiting period, as in the case of one mother, ready and eager to surrender her child, who tightened up so literally the day before the surrender that she had to be catheterized. She relaxed for normal functioning following an interview in which a decision to postpone surrender was reached.

RE-EVALUATION

A routine re-evaluation is scheduled shortly before the final legal adoption procedure is carried out; the child is usually between 12 and 13 months old. The primary function of the re-evaluation is to measure the child's intellectual abilities by standardized tests. Since we are a child guidance center, accustomed to seeing a child as a dynamic part of family interrelationships, our re-evaluations go one step further and utilize the formal re-evaluation testing session as a structured opportunity to study the family's interpersonal relationships. Thus, we insist that the entire immediate family accompany the baby to the center.

When the family arrives and gets settled in the waiting room, the psychologist appears and is introduced by the social worker. His function is to form a relationship with the baby. While this occurs, the psychiatrist appears, is introduced by the social worker and sits quietly by, observing the infant. Her function is to note the interrelationships that occur. She may chat with the parents or play with the baby or with a sibling or sit quietly, depending on the situation. When it is felt that the baby is ready, he and the parents are invited to accompany the psychologist and psychiatrist to the testing room. There are specific places for each one to sit. The Cattell infant intelligence test is then administered. During the test the parents are encourged to talk about the infant. This will be accomplished in a variety of ways depending on the type of parents. With some, no encouragement is necessary; with others, the psychologist might comment on the way the baby deals with frustration, or tries to avoid performing;

with still others, the psychiatrist may start by asking if toilet training has been started or if the child is still on the bottle. In general, the psychologist focuses on the child's behavior in the test while the psychiatrist concentrates on his general developmental progress.

It is rather difficult to describe specifically how to encourage parents to discuss their child and bring out their questions and anxieties. We feel that receiving support within a welcoming setting where professional workers obviously enjoy contact with them and their baby tends to foster discussion that is invariably cut short by lack of time. Parents enjoy talking about their children and in a favorable psychiatric setting will express whatever questions and doubts they have about a child's growth and behavior. Parenthetically, the main conflict they verbalize is about their neighbor's questions: "Is Johnny still on the bottle? Isn't he weaned yet?" or some such nonsense. Evidently when an adopted child arrives in the neighborhood the neighbors automatically assume the role of critics. The psychiatrist's comment to the mother—that she is doing a marvelous job and to keep on loving and enjoying him, that she and not the neighbor is the child's mother—always elicits a sigh of relief and an "I told you so" glance at her husband. The center's role with the parents is to handle all questions that can be dealt with in the time available and to support the parents in the job they are doing with their youngster.

Our experience has highlighted three common patterns of infant behavior. The first we call the "almost" pattern. Here, the infant's approach to testing is tentative. On the Cattell test tasks he "almost" achieves on many items. His handling of material is "delicate"; if we remove a toy from the infant and offer him an alternate, he freezes and seems to be afraid to accept anything new. We find that this response pattern seems most often to be related to overprotective handling by parents who inhibit the infant's motility. They see the infant as a delicate entity to be protected from all "harmful" experiences. Although most children, given the freedom of the testing room, wander about exploring, this one stays close to his mother. The second type is the overactive infant. He finds it difficult to sustain attention and complete any task. Toys fly; frustration and anger are readily precipitated. We find that this response pattern seems most often to be related to inconsistent handling where the infant is expected to respond to a variety of limits far beyond his capacities. Frequently we find that there is more than one "boss" to whom the infant is expected to respond, that there is an aunt or grandparent in the home undermining mother's confidence. The third type is the fearful infant. He cries easily, withdraws from strangers, and when comfortable is quite rigid in his behavior. He finds it hard to shift from one toy to another and will spend the period, if he is allowed, exploring a single toy. Needless to say, the mothers of these fearful infants are fearful women.

While the foregoing "types" are described as specific entities, we hasten to add that we rarely see these as sharp clear-cut patterns. It is a matter of degree, and the handling of the parents of these infants varies with the severity of the behavior pattern.

In the event that the youngster being tested has an older sibling the physchologist, after testing the infant, leaves the testing room and strikes up a relationship with the older child, who has been playing with the social worker in the reception

room. An evaluation based on the administration of the Despart fables and on our observation of the family group will frequently elicit a picture of the effects of the new baby on the sibling. We have had several instances in which the older sibling has suffered unduly because of the parental need to invest most of their attention in the baby. This is dealt with during the re-evaluation if possible, but more frequently we will recommend to the adoption agency that final adoption be postponed until the social worker has helped the parents with this problem. Our philosophy is that we are dealing with a family unit. We feel we must constantly be on guard lest we become too overprotective of the infant.

The session is terminated with an open invitation for the parents to feel free to return to the center at any time to allow us to share in their child's progress.

RE-EVALUATION CONFERENCE WITH PLACEMENT AGENCY

Immediately following the re-evaluation session, the psychiatrist, psychologist and placement agency's social worker meet to discuss the center's findings. Any questions raised by the agency's social worker are discussed and a decision is made concerning the advisability of further supervision of the family and retesting or normal adoptive procedures and termination. In our experience about 3% to 5% of the cases have required further case work. At no time has there been the slightest need to consider removing a child from an adoptive home. We have been constantly impressed with the excellence of these homes.

COMMENTS

In our frequent re-evaluation of the adoption program, we have come to realize the importance of the role of a "comfortable authority" in infant evaluation and placement. We know that the local demand for this service is not related to our ability to diagnose and pinpoint where a child falls on a developmental scale, since we neither claim nor can do any such mystical feat. We feel that any pediatrician, nurse, psychologist or social worker experienced with infants can spot an uncomfortable child. The fact that our psychiatrist is a trained pediatrician adds the dimension of a clear concise recognition of the physical factors involved. Add to this the layman's mystic interpretation of the value of a psychological test and our service is vested with authority.

We feel that assumption of the role of "comfortable authority" is the essence of our service. The placement agency, the boarding parents, the nurses and the adoptive parents know we love and cherish and take pride in each of the infants just as they do. We are comfortable in the work we do and they are comfortable in sharing the work they do with us. We do not feel this reflects complacency but a genuine belief in the capacities and wonders of the infant.

CLINICAL FINDINGS AND MENTAL HEALTH

It was not until recently that we became aware that no infant we have seen, except those with known neurological damage, has rated below I. Q. 100 during retest at 12 to 14 months on the Cattell scale. A project to retest at the age of 5 and 8 years is now in the formative stage. We have also been impressed with the relatively excellent mental health of all the infants we have re-evaluated. Our experience has led us to wonder if these measures of preventive care could be carried over into the community

of natural parents and their infants through a purposive educational effort. Our experience offers hope for achieving a reduction in mental retardation and an improvement in the mental health of families.

SUMMARY

A method of integrating the skills of a child guidance center with those of an adoption agency has been described. Infants were evaluated and placed with adoptive parents prior to the child's fifth week of life. They were re-evaluated between twelve and sixteen months of age. The parents and siblings were included in the re-evaluation process.

The guiding principles of this program are fourfold: 1) the earliest possible adoptive placement of infants, 2) the identification of atypical infants and the definition of their special needs, 3) support, recognition and handling of the placement agency social worker's anxiety, and 4) support, recognition and handling of the adoptive parents' anxiety concerning their child.

Clinical impressions of the children participating in this program suggested superior mental health. Intelligence testing at the time of re-evaluation suggested positive significant differences in the level of intelligence of these children compared with the normal curve of I. Q. distribution. There are indications that this process of adoption contributed significantly to the mental health and to the maximal utilization of the intelligence of these infants.

It is postulated that this service falls within the educational and prophylactic function of a child guidance center and that this service is a definable service which can be duplicated in any community.

The question has been raised as to the value of similar services for natural parents and their infants.

A. B. ABRAMOVITZ
ELAINE BURNHAM

Exploring potentials for mental health in the classroom

An attempt will be made here to describe concisely the experience of three clinical psychologists in planning and teaching an experimental mental health course given concurrently at three state colleges (La Crosse, Stevens Point and Whitewater) several summers ago. In the present paper we are limiting ourselves primarily to an expression of our impressions, feelings and reactions.

Despite the very complex and difficult phenomena involved, the essence of the underlying philosophy and intent of these courses can be simply and briefly stated. This philosophy has been aptly expressed by the mental health committee of the U. S. Office of Education: "The theory that teachers tend to teach as they are taught applies with equal force to mental health. Unless teachers are prepared to teach and practice under conditions favorable to mental health they are not likely to understand what it means to children to work in a favorable emotional climate. Indirectly, therefore, the road to mental health for children is mental health for teachers. This is not to suggest that most or even many teachers are neurotic, but it is to suggest that the situation can be and is being improved." [1]

Another fundamental aspect of the thinking underlying our experiment is very effectively brought out by Murphy and Ladd:

Mr. Abramovitz is director of the division of child guidance in the Wisconsin State Board of Health, and Miss Burnham is a clinical psychologist there.

[1] Committee on Academic Education, American Psychiatric Association, Information Memo No. 3, May 1953.

"When emotional factors in learning are seen to be important not only in problem cases but also in a large proportion—if not all—of the student body, guidance becomes a preoccupation of every day, rather than the subject of a semi-annual visit to the dean." [2]

One of the purposes of the summer project in the colleges was to provide in-service training for psychologists in the techniques of mental health education. This is an important function for which original professional training provides very little and for which in realistic job situations there are imposing demands. Most of what psychologists and other clinicians acquire in pertinent skills is usually on a trial and error basis in on-the-job experience.

A second purpose was to find ways to increase the practical value of mental health materials and concepts to teachers in regular classroom work.

The courses were set up for the full six weeks of the summer session. Enrollment was limited to about twenty experienced teachers at each of the participating colleges. A mild selectivity was exercised in admitting the teachers to these courses.

In the catalogs the course was titled Classroom Use of Mental Health Teaching Devices. The focus was deliberately placed on the teachers' everyday class situation with special reference to applying mental health insights and principles, rather than on case studies of children with problems. This was even more specifically channeled by emphasizing the use of such teaching aids as filmstrips, mental health plays, motion pictures, publications with significant psychological content, children's phonograph records, etc. The courses were conducted primarily through informal discussions, laboratory-like exploration of the teaching materials, and some practice-teaching opportunities with children in laboratory schools. The fundamental assumption was if the instructors through their methods and relationships with their students conveyed sound mental health concepts and practices, the students would be enabled to convey the same to the children in the practice-teaching groups.

Since these courses were an exploratory attempt and a new experience for the instructors as well as the students, it was felt that the most logical and desirable first step in evaluation would be an unstructured conference shortly after the close of the courses. The three instructors would be the only participants and they would have an opportunity to exchange their feelings and reactions extemporaneously. On the assumption that these three psychologists represent a fairly typical sampling of such personnel as may be found in child guidance clinic work and that the gap between classroom teaching and clinical understanding (which we were trying to learn to bridge through this project) represents a significant and fairly universal problem, it is deemed worth while to present a considerably abbreviated version of this conference. Probably educators will be just as interested as clinicians in these deliberations.

The very first question that arose and seemed so basic to all that followed was whether clinicians and teachers have a common understanding of the very meaning and nature of the teaching-learning process. What is teaching? What is learning? How do these occur? As psychologists we felt that learning involved something broad in its effect on the personality and behavior of the learner. In contrast, we wondered whether the teacher is more concerned with

[2] Murphy, Lois B. and Henry Ladd, *Emotional Factors in Learning*. New York, Columbia University Press, 1946.

getting a fairly specific response to a specific stimulus and less concerned with change in the organism. The concept of learning as a specific response to a definite stimulus usually carries with it a predetermined objective of the teacher. The teacher wants the student to learn a fact or method which she has assumed in advance is desirable for the student to learn. Often nowadays teachers try to have pupils participate freely and purposively in learning. Such democratic classroom procedures may, however, obscure the fact that the learning may fail to become a vital part of the pupil as a person.

It was noted that there would probably not be any significant disagreement as to concepts of learning and teaching between the clinicians and the teachers on a verbal or intellectual level. Yet under the pressures of actual teaching the practice seems to differ from the theory. Obviously there are enough individual differences among teachers and sufficient variability of any individual teacher that this is not a black and white discrepancy. We wondered what might be the outstanding cause of failure to apply consistently in practice what was agreed with verbally. Might it be the individual teacher's feelings and attitudes perhaps more than any other factor? In essence, it seems that the pupil learns as he is taught rather than according to any theory the teacher may profess.

We found in the three courses that most of the teachers had a great deal of previous experience that ran counter to the procedures and thinking guiding the instructors, who were trained as clinical psychologists. A number of the students showed strong resistance—a few even dropped out of one group during the first week. Much of the resistance seemed to center about the fact that the instructor was not giving the customary reassurance that there would be either tangible answers or definite rights or wrongs to the questions being considered. For certain individuals this kind of flexible and indefinite structuring of a learning situation is very threatening and anxiety-producing.

Frustration was expressed by the psychologists over the fact that in a teaching-learning situation of this type a 6-week period was very short to expect much progress. Some of the frustration was eased by recognition that others working with this problem have noted it takes a long time to achieve a good effect and there is no way to make satisfactory short cuts. We were glad we could reduce our own anxiety over this so that our uncomfortable feelings did not make things more difficult for our students. In a sense this is one of the most important mental health concepts we could wish for teachers to grasp: that they try to avoid injecting into learning situations (even subtly) anxious pressures to speed up a process that needs to take its own natural course at its own appropriate rate.

In continuing to explore the meaning and nature of learning and change in the learner, the question was asked whether it is possible to make a deliberate change in any student through teaching. It seemed to us possible for the teacher to prepare the ground, so to speak, and to help with planting the seed, but the rest seemed to depend primarily on the learner. However, just as the teacher may facilitate a change in the learner so may the teacher hinder change.

As we observed the teachers in these courses it seemed that many of them wanted to have learning take place through the presentation of factual material for the pupils to absorb and repeat. Rather subtle and complex difficulties were encountered in the teachers' attempts to break away from such an approach. The teachers

seemed to manipulate the learning situation and to implement the manipulation by pressures of one kind or another to induce, cajole or even force change in the learner, no matter how limited a change might be. Even in dealing with emotionally-charged materials such as mental health films, the teachers adhered closely to the limited objective of producing intellectualized understanding and response to content, while remaining relatively unconcerned about the learner's feelings, attitudes and functioning as a whole person.

From the clinician's standpoint "good learning" depends considerably on a learner's genuinely accepting and taking responsibility for his own behavioral change. We wondered whether that does not contrast sharply with what happens in many classrooms. How many teachers would say that a condition of genuine learning is that all pupils in the class must somehow have achieved a state in which they have not only acknowledged, but also worked through, their responsibility for their own learning? There is frequently confusion as to what constitutes responsibility. Often lurking in the background is a concept of "will power," some kind of conscious volitional activity. It is thought that this will power can step up quantitatively the child's use of his innate capacities, his motivations and so on. In this summer project we learned that for some teachers there is a basis in their own life experiences and educational background for this great emphasis on the volitional stepping-up process. When there is overemphasis on the factor of will power there is likely to be a concomitant omission of regard for all the dynamic emotional forces that are part of the natural fabric of learning.

When one has too simplified, too rational, too intellectual a view of learning one thinks of applying more energy of some kind as a means of overcoming obstacles in a rather direct one-to-one logical relationship. For example, if all that is essential in learning to read is to pay attention or try hard enough, and the child does not learn, then the rational, intellectual solution is simple enough: All that is necessary is to turn on the control in higher degree, to pay more attention, try harder and overcome the obstacle. But the clinician feels that the forces determining learning, both quantitatively and qualitatively, are not so direct, nor so logical nor quite so open to conscious control. Paradoxically, some of these logic-based solutions may be totally illogical and inappropriate.

Clinicians, varying individually of course, will in one way or another, to one degree or another, have some of the teachers' orientation to learning. It may be to the benefit of all that clinicians do have some of these intellectualized attitudes in common with others. Otherwise, clinicians and teachers would have less adequate means of communicating with each other. Perhaps one of the first things that takes place in trying to overcome the gap between clinicians and teachers is some kind of identification based in part on communication through shared attitudes. For this to occur it is necessary that the clinicians should have outgrown certain attitudes and have gained insight into and objective understanding of the same attitude problems in other people. This will better enable the clinicians to be non-judgmental and genuinely helpful to others.

As a matter of incidental significance, the question might be raised whether clinicians, generally speaking, have been attracted to their field of work at least in

part because of conflicts related to the traditional type of education.[3] If this is true, clinicians may be in a defensive role when they have to deal with educators, particularly in the role child guidance clinicians commonly play (that is, mainly as intercederers for the well-being of children who are in conflict with educators). If the people in teaching have been attracted to their profession because of factors in their own background which have made traditional education congenial to them, they will likely be defensive in relating to clinicians, especially over the common problems of children who present learning or educational difficulties of any kind.

An assumption basic in setting up these courses, in the light of just such considerations, was that teachers would have to begin at the point of becoming sensitized to themselves and their own educational experiences, broadly speaking. Obviously there can be no special technique or direct approach even to setting in motion such a process of sensitization. Furthermore, since this was not a therapeutic procedure, but rather educational, a careful attempt was made to avoid turning this into too personalized an experience and to avoid probing or insight-giving on a personal level. Accordingly, the focus was more generic, concerned with teachers as professional workers. We felt this focus would open up the possibility for each teacher to apply to himself or herself whatever seemed fit, and go as far as he or she wished and comfortably could. It did not seem at all surprising then that we found —regardless of the chronological or professional age of the individual—well established defenses brought to bear on all phases of the course. The instructors felt it very important to respect and safeguard these defenses that the teachers called into play. We believed that for all practical purposes the most that could be achieved was to help them utilize as much or as little as they could within the framework of their own defense systems. From one standpoint this proved to be difficult and frustrating for the instructors since progress under such circumstances was extremely slow and in some instances almost imperceptible.

There was one place where the defense systems were challenged. This related to the teachers' tendency to abstract individual problem children from the class for special concern and attention on the basis that these children deviated from a pattern that was thought to be desirable and to which the majority of pupils seemed to conform. From material we gathered during the course it seemed obvious that the chief basis for this attitude of the teachers was their own relative success in using conformity as a defense. This defense, in other words, was being projected on the so-called problem children in their classes. The instructors challenged this by focusing firmly and consistently on the need to be concerned with all pupils in the class and on seeking ways to help even the deviates through the general classroom procedures. For some of the teachers this challenge was difficult and conflict-provoking. Even in the short period of the 6-week summer session, however, it seemed possible at least to help them over the hump of this conflict.

There was wide variability among the teachers in the three courses in chronological age, years of teaching experience, and

[3] Bloch, Donald A., "Some Concepts in the Treatment of Delinquency," *Children*, (March-April 1954), especially 53–54.

even formal professional training. In the opinion of the instructors, none of these factors seemed to determine how effectively the teachers either perceived and utilized what the course had to offer or what they were able to do along the same lines themselves even before they took the course. A much more important determinant seemed to be their capacity to think about and react to children in a manner that may be termed dynamic. This means the capacity to understand and respond to children in ways that go beneath the surface and purely rational level, the capacity to understand cause-and-effect relationships in children's behavior, to give adequate recognition to feelings and attitudes and the "meaning behind words."

The fact that teachers are often men and women who have gone through difficult adjustments in their own lives stood out in the observations of the instructors. Furthermore, they seemed to have a good deal of ego strength in either overcoming their problems or learning to live with them. They seemed to be eager to help children either avoid unhappy problems or overcome them with the same ego power they themselves had been able to muster. It is not surprising that since so much of their own control over their problems is intellectual, they would like to transfer the same intellectual capacities to their pupils. These are observations the instructors made and for which some substantiation was obtained in less subjective ways during the summer course.

Since it is unlikely that many children will show these unusual capacities—apart from the question of whether it would be desirable—we felt that we had identified here a great stumbling block between teachers and their ability to promote mental health and good learning in their pupils. We have no easy or ready solution. We would suggest, however, that perhaps an ongoing program during original training and an in-service training attempt to help teachers to be more objective toward pupils—in the sense that they not project upon them their own problems or modes of solution—would be of considerable value toward removing the stumbling block. Another conviction strengthened through the summer experience was that the challenge to teachers to focus less on the abnormal and unusual situations of some individual pupils and more on the group teaching process in the classroom would also help considerably.[4] Finally, the conclusion was reached that helping teachers to understand cause and effect and meanings in children's behavior would in the long run prove extremely valuable. It should also be reiterated that we felt more strongly than ever the truth of the view that "although there is a priority of need for teachers to understand the social and emotional aspects of child development, it is clear that understanding on a conceptual-verbal level is insufficient."[5] "Self-knowledge in depth" as a basis for both teaching and learning seems not only essential but also realistically possible.[6]

ACKNOWLEDGMENTS

We would like to acknowledge here our gratitude for the excellent cooperation given by the three colleges as well as by the Board of Regents of Wisconsin State Colleges. We also wish to express gratitude to Norman Brown of Kalamazoo, Mich., for

[4] Sanford, Fillmore H., "Psychology and the Mental Health Movement," *American Psychologist*, February 1958.

[5] School of Education, University of Michigan. Proceedings of the Conference on Human Relations and Human Development, 1953.

[6] Kubie, Lawrence S., "Psychoanalysis and Marriage," in *Neurotic Interaction in Marriage*. New York, Basic Books, 1956.

his considerable share in this experiment, both in teaching one of the courses and in helping to do the evaluation on which the present paper is based.

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HANNAH D. MITCHELL, R.N., M.P.H.

Making interviews by public health nurses more effective

The Georgia Department of Public Health has endeavored to bring about a more practical and profitable use of public health nurses in direct and indirect mental health activities. Increased funds for mental health programs since the passage in 1946 of the National Mental Health Act has made such effort possible. Supportive services to families of the mentally ill by the public health nurse in Georgia is illustrative of what has been accomplished without elaborate expenditure of funds.[1] The public health nurse is currently receiving in-service training in interviewing which is economical and yet pays tremendous dividends in interpersonal communication.

The nurse is constantly in the process of developing patient interviews. The question was raised by one of our psychiatric consultants as to the impact on the mental health of Georgia's people if the public health nurses could be taught to *listen* to patients. At about the same time, a maternal and child health director recog-

Miss Mitchell is assistant to the director of health conservation services for the Georgia Department of Public Health.

[1] Beasley, Florence A., "Public Health Nursing Services for the Families of the Mentally Ill," *Nursing Outlook*, 2(Sept. 1954), 482–84.

Beasley, Florence A. and William C. Rhodes, "An Evaluation of Public Health Nursing Services for Families of the Mentally Ill," *Nursing Outlook*, 4 (Aug. 1956), 444–47.

Rice, Guy V., "The Role of the Public Health Nurse in the Hospitalization of Mental Patients and Their Follow-Up After Discharge," *American Journal of Public Health*, 47(Feb. 1957), 210–214.

nized that the interviews in the maternal and child health conferences were not the best that could be desired. Public health nurses themselves asked indirectly for instruction in interviewing when they asked how to get patients to talk and when they said patients failed to pay any attention to what they told them.

Joint planning began with committee representation from the maternal and child health, mental health and nursing divisions. It was decided to hold a series of workshops on interviewing with members of the central state health department staff and supervisors from local public health departments with the idea that if these were successful similar workshops on regional and local levels would be held.

Two objectives for these workshops evolved:

- Improving services to patients by increasing the ability of public health workers to communicate. Such an undertaking would prepare the nurse to assume a more pronounced listening role. The matter of listening to the patient would in itself be a service and would open areas whereby assistance could be rendered to the patient.
- Providing an opportunity for all medical, nursing and nutrition personnel in administrative, consultant and supervisory public health to increase their understanding of the essentials, techniques and skills in interpersonal communication by focusing on the subject of interviewing.

Consultants were brought in from U. S. Public Health Service, Children's Bureau, Emory University and other outside agencies to assist in giving didactic material and to observe live interviews and provide consultation to the interviewers afterwards.

The workshop focus was the expectant mother but it was realized that the principles applied equally to all types of interviews. The expectant mother was chosen because the public health nurse devotes much of her time to this group and because these interviews sometimes become a matter of the nurses "telling" the patient rather than "listening."

The first workshops were not limited to nurses but included other disciplines such as physicians and nutritionists. Several workshops of four days each were held since all of the above personnel could not come to one meeting.

Considerable anxiety, in both individuals and groups developed in some of the groups. It is our desire to follow these groups to determine the relationship between anxiety and follow-through.

Some of the elements of the patient-worker relationship considered were:

1. The structure of an interview.

2. The essentials—the "musts" of an interview; the atmosphere conducive to conducting a satisfactory interview.

3. The techniques—tools used in an interview.

4. The skills—adeptness or ease in using the techniques.

Those participating in the discussion of anthropological factors came to realize the difficult barriers between those of differing cultures. This understanding brought a greater opportunity to transcend such obstacles in the relationship between the patient and the worker.

The value of silence by the worker and of non-verbal communication by the patient were considered. In some observed interviews, the interviewers prolonged the socialization relationship. Quite

a few did not recognize the patient's right to terminate the interview.

How did the various groups feel about their part in the workshop? The patients expressed an appreciation for having time to talk out some of their problems, and one or two returned to subsequent workshops. At the beginning of each workshop some of the participants felt they needed no further preparation in interviewing. A few asked for observation of an interview by an "expert." There was resistance by the consultants about filling such a request. The consultants were fearful that the participants would feel it should be a "perfect interview." An attempt was made once to meet this request. The consensus after the staged interview was that "the only way to learn how to interview is to interview." Most of the participants enthusiastically felt that skillful interviewing brought much satisfaction to the worker. There was a general feeling by the participants that they were learning how to get from the patient information about her feelings and her problems. All became aware of the nonverbal elements of communication.

Following the workshops we have noticed a considerable increase in skilled interviewing by participants. Two similar workshops have been held on a regional level and one in an urban community. Continuing interest has been expressed by many individuals.

We believe that greater facilitation of communication is one of the principles involved in the promotion of good mental health. The training described, while it cannot be definitely measured, improves communication between the professional worker and the patient and thereby adds to the general mental health of the community.

LOUISE VIETS FRISBIE, M.S.S.

Treated sex offenders and what they did

This paper is an interim report based on data being assembled over a 5-year period on factors in recidivism among psychiatrically treated sex offenders. To date there has been an excess of conjecture rather than documented fact from both a medical and legal standpoint on the issue of sexual psychopathy. The Atascadero State Hospital, opened in June 1954, offers a unique research opportunity because it was designated as the one California facility for the observation and treatment of sex offenders in accordance with statutory requirements.

It is usually assumed by the general public that the molester of female children is an old man more or less in his dotage, that an incestuous relationship between father and daughter seldom occurs, and that such a relationship between father and stepdaughter also is rare. The molester of male children is assumed to be the middle-aged tramp or hobo who entices little boys into culverts or vacant buildings. These assumptions are exploded by examination of the records through October 31, 1957 of 1,114 convicted sex offenders who were discharged from Atascadero State Hospital after psychiatric treatment with a statement to the committing court that the patient had improved and was no longer considered a menace to society.[1]

Mrs. Frisbie is a psychiatric social worker for the California State Department of Mental Hygiene assigned to Atascadero State Hospital. Her paper expands pertinently on the general information supplied by Paul Kivisto in his article, "Treatment of Sex Offenders in California," in *Mental Hygiene*, 42(1, 1958), 78–80.

[1] Section 5517-b, California Welfare and Institutions Code.

Under the California law on sexual psychopathy [2] the superintendent of the Atascadero State Hospital has the privilege of selecting for treatment only those convicted sex offenders who are deemed treatable and who qualify under the law as having a pattern of abnormal sexual desire and are a menace to the health and safety of the public. The child molester is the prototype of this definition and thus should properly make up the largest group of Atascadero State Hospital patients.

The first discharges from this hospital during 1954 and early 1955 comprise those patients who were originally admitted for observation and treatment at Mendocino and Metropolitan State Hospitals. The philosophy and interpretation of the law by the superintendents and staffs of those hospitals was somewhat different from that at Atascadero State Hospital in respect to an offense of rape or assault with intent to commit rape on adult females. The superintendent and staff at Atascadero State Hospital usually regard these sexual offenders more properly as criminals within the meaning of the law, for in such cases the offense ordinarily represents absence of control over normal temptation and normal sexual desire. Furthermore, we consider the precise definition of the legal term *sexual psychopath* as inapplicable in instances of homosexuality between two adult males where there is in effect a willing partner, not a victim. This is private abnormality, not publicly menaceful behavior. It is therefore obvious that among the patients committed to Atascadero State Hospital for observation and treatment a minimum number will represent those convicted of rape of the adult female or of adult homosexuality, and presumably only when such convictions are symptomatic of a pattern of other uncon-

[2] *California Welfare and Institutions Code and Laws Relating to Social Welfare,* Sacramento, 1955. See Division 6, chapter 4, section 5500, page 283.

TABLE 1

Frequency of type of sex offense

CHARACTERISTIC OF OFFENSE	NUMBER OF CASES	PERCENT OF CASES
Physical contact	905	81
Molesting child	846	76.0
Molesting adult female	49	4.0
Molesting adult male	10	1.0
No physical contact	209	19
Indecent exposure	136	12.0
Vagrancy *	27	2.4
Peeping Tom	18	2.0
Transvestism and/or stealing women's lingerie	13	1.1
Lewd telephone calls	10	1.0
Arson	4	0.4
Possession of narcotics	1	0.1

* Includes masturbating in car; loitering in park or near swimming pool or school grounds; masquerading as a woman.

trollable neurotic sexual misbehavior. The effect of this selection process will be more clearly disclosed as the volume of discharges increases.

The degree of menacefulness is debatable in those sex offenses where there is no physical contact. Society, however, is annoyed by the habitual exhibitionist who mocks propriety and convention, the Peeping Tom who invades privacy, and the maker of lewd telephone calls who forces his vulgarity upon a victim usually selected at random. Obviously these persons have abnormal and uncontrolled desires. Incarceration in jail or prison serves no useful purpose since the deterrence factor is not applicable to the man who has neurotic compulsive behavior. Treatment in a psychiatric setting serves society more advantageously.

For purposes of clarity, in Table I the categorizing of patients by type of sex offense is in arbitrary groupings according to physical contact or no physical contact. Of 1,114 cases, 76% are child molesters.

In Table 2 the age of the patient is computed in relation to the date of his admission to Atascadero State Hospital. This is reasonably accurate in assessing the patient's age at the time of his conviction because the pre-trial jail period rarely exceeds 90 days and is usually shorter. Hospitalization follows rapidly after the superior court hearing on the issue of presumed sexual psychopathy. Among those cases transferred to this hospital from Metropolitan and Mendocino State Hospitals, however, the patient would actually have been younger when the crime was committed because the admission date to Atascadero State Hospital is less closely related to the conviction date.

TABLE 2

Age distribution of sex offenders

YEARS OF AGE	NUMBER OF CASES	PERCENT OF CASES
15–19	25	2.2
20–29	314	28.2
30–39	323	29.0
40–49	179	16.1
50–59	130	11.7
60–69	93	8.3
70–79	46	4.1
80–89	4	0.4

TABLE 3

Frequency of child molestation by sex of victim

SEX OF VICTIM	NUMBER OF CASES
Girls	579
Boys	229
Girls and boys	38

It is apparent that these sex offenders are predominantly young men whose median age is 36.7 years with 59.4% of the total number falling into the age grouping below 40 years. This closely parallels findings on British sex offenders where 64.6% in a study group of 1,985 men were under 40 years of age.[3]

Special attention will be directed to the characteristics of the child molester since these men represent 76% of our study group. The actual conviction may represent an offense varying from one extreme of holding a child on the lap and/or kissing him or her, through digital manipulation of the genitalia, to forcible rape. Whatever the act, there is assumed to be some degree of sex gratification experienced directly or indirectly by the child mo-

[3] Radzinowicz, L., *Sexual Offences—A Report of the Cambridge Department of Criminal Science,* New York, Macmillan Co., 1957, p. 113.

lester. The ratio of cases of molestation of girls is approximately 2½ times as frequent as molestation of boys, but it must be remembered that in many cases of both sexes there is more than one victim.

That the child molester is not necessarily a senile old man becomes clearly demonstrated in Table 4. Fifty-three percent of the child molesters are under 40 years of age. This is compatible with the median age of 36.7 years for all sex offenders in the study group.

TABLE 4

Age distribution of sex offenders comparing all offenses with child molesting

YEARS OF AGE	ALL CASES	CHILD MOLESTING CASES
15–19	25	13
20–29	314	191
30–39	323	247
40–49	179	147
50–59	130	116
60–69	93	85
70–79	46	43
80–89	4	4

To what extent is consanguinity a factor among child molesters and female victims? No attempt is made here to differentiate between fondling and actual incest with penetration because of the lack of uniformity by the courts in the application of the term *incest*.[4] For study purposes, then, all daughter and stepdaughter victims are categorized broadly as child molestation cases and represent 26% of the total child molestation cases involving females. In one-third of the 98 cases involving a daughter, the father (patient) was between 30 and 35 years of age.

TABLE 5

Frequency of consanguinity among female victims

RELATIONSHIP OF VICTIM	NUMBER OF CASES
Daughter	98
Stepdaughter	56
Daughter and male child	8

The median age of the child molester's female victim is 8.8 years and of the male victim is 12.3 years. The total number of victims in Table 6 is based on statistics through August 31, 1957 and hence does not coincide exactly with figures cited previously.

TABLE 6

Age and sex of victims of child molesters

AGE OF VICTIMS	SEX OF VICTIMS	
	Girls	*Boys*
0– 2	7	0
3– 5	76	12
6– 8	228	44
9–11	192	67
12–14	71	108
15–17	18	39
18–20	2	1

SUMMARY

The findings in this inquiry[5] show:

1. Eighty-one percent of the offenses involved physical contact.

[4] *Deering's Penal Code of the State of California.* Revised 1949. Section 285, page 85.

[5] For an earlier report, see Louise V. Frisbie, "The Treated Sex Offender," *Federal Probation*, 22(March 1958), 18–24.

2. Seventy-six percent of the offenses represented child molesting.

3. The median age of the sex offenders was 36.7 years.

4. Approximately 2½ times as many girls as boys were victims of the child molester.

5. Among the cases of female victims of child molesters 26% were daughters or stepdaughters.

6. The median age of the female victim of the child molester was 8.8 years.

7. The median age of the male victim of the child molester was 12.3 years.

GERALD CAPLAN, M.D., D.P.M.

An approach to the education of community mental health specialists

The Harvard School of Public Health program of education for community mental health specialists has been developing over the last five years as a special endeavor of our mental health section. This section was established ten years ago under the direction of Dr. Erich Lindemann for the primary purpose of providing instruction to public health students in the principles of community psychiatry. Our approach to the education of mental health specialists has been much influenced by our collaboration in this program with our faculty colleagues from other departments of the school, and also by our need to reformulate our psychiatric ideas to fit them appropriately into the frame of reference of our general public health students.

It may be well, however, to emphasize that our current thinking is fundamentally based upon our own clinical experience and researches, which over the years have been moving steadily from their early focus on the psychosomatic pathology and the psychotherapeutic and psychoanalytic treatment of the individual patient to an interest in the etiological forces in his social environment, and then on to the possibility of controlling these noxious factors in order to lower the incidence of mental disorder in a community. Our approach to community mental health is focused mainly on the organization of specific pro-

Dr. Caplan is associate professor of mental health and head of the mental health section at the Harvard School of Public Health. He delivered this paper at a conference on training for the community mental health professions, organized by the California Department of Mental Hygiene and held August 24–27, 1958 at Berkeley.

grams for the prevention of mental disorder, and although the planning of these programs is directed towards the study and management of factors at the community level, our appraisal of these factors is colored by our old clinical frame of reference, and many of our operating techniques are derived from individual psychiatric practice.

I draw attention to this aspect of the development of our approach because it is linked to two major problems which today face the student of community mental health and his teachers.

Firstly, there is the need to define a manageable area of the field which can be made the primary focus of study. Recent thinking which emphasizes that "positive mental health" involves something much more than merely the absence of mental disorder, while certainly valid, may imply widening the universe of discourse to include so vast an area that planning a curriculum becomes almost impossible. By narrowing our focus to the prevention of recognizable mental disorder we have carved out for ourselves and our students a part of the field in which we can hope to achieve specialized competence, and across the borders of which we can offer collaboration to the many other professions who have a stake in positive mental health.

The second problem derives from the need of the clinician who has previously focused on the individual patient to acquire new frames of reference in order to comprehend community factors and their modification. Most of us clinicians who have specialized in community mental health have passed through a rather painful and difficult phase of professional development as we have come to the surprised realization that the frame of reference of psychodynamic psychology and psychopathology, which served us so well in dealing with individuals, was quite inadequate in conceptualizing the dynamic factors influencing the group and the community. Whence then were we to derive the additional conceptual tools and skills? Many of us quite naturally turned for help to those professions which had traditionally been operating at the community level, to the social scientists and to the members of the public health professions—the epidemiologists, the biostatisticians, the health educators, the public health administrators and the other community practitioners. As one might have expected, we have not found that any of these professions has been able to give us specific answers to very many of the questions we have felt it important to ask. Each of these professions has developed conceptual frameworks and ways of operating which have been designed to answer questions important to themselves. We can borrow something from most of them, but in the final analysis the concepts and techniques we can profitably use for our own professional needs must be developed within the context of our own professional reality.

Although the various community sciences and professions can provide us with few ready-made answers to our questions, they certainly have much of value to offer if we can adapt their tools to our specific purposes. The problem for the community mental health student and his teachers is how deeply to delve into the mysteries of each and how to avoid becoming utterly confused by the acquisition of quite different, although to the outsider deceptively similar, frames of reference and conceptual systems.

This is an emotional as well as an intellectual problem, and we believe it is basically a question of the worker's ac-

quiring a new professional identity[1] as a community mental health specialist. When security in this indentity develops, it is possible to view with clarity the systems and concepts of other professions and sciences and to borrow and adapt ideas of potential value without feeling and behaving like a dilettante.

The difficulty at the present time is that although community mental health programs have been in operation for many years there are still too few established specialists to act as an adequate professional reference group and no distinct professional identity has as yet emerged which a student may incorporate. We therefore have largely to fall back on individual role models, and this leads to the danger of cultism among disciples who may wish to escape from the insecurity of our present ignorance in this field by placing their faith in the words of the master. This is a danger which must be borne in mind not only by students, but even more so by their teachers.

At Harvard we have adopted one other approach to this problem, and that is to make use of the opportunity presented by our operating within the framework of a school of public health. The profession of public health carries its own professional identity which transcends the identity of the component professions and sciences. One of the goals of such a school as ours is to enable all its students, whatever their background and future specialty, to incorporate this basic identity. We feel that until community mental health has developed a professional culture of its own one of the ways of helping our students to incorporate the community approach is to encourage them to become public health men. In line with this, we have advised our students to attend a variety of courses at the school, not only to learn specific curriculum content but also to acquire a public health point of view. We have also encouraged a considerable amount of interaction, informally as well as formally, with the public health students of other specialties, so as to promote a "we feeling." In this we have been greatly helped by the fact that at Harvard many of the public health courses are taught in seminars and small tutorial groups and through the medium of team projects in which the students collaborate over several weeks or months in carrying out specific learning exercises.

Before ending these introductory remarks I would like to refer to one other technical problem. Education in community mental health is at present made difficult because no generally acceptable systematic body of knowledge has as yet been developed which satisfactorily encompasses the subject. Even if we narrow the field to the prevention of mental disorder, it cannot be said that we are today very advanced in being able to conceptualize the theoretical framework or the practical methodology upon which fruitful work may be based. If we wish to educate students rather than to train technicians, we must make a special effort, even at this early stage, to put down on paper in quite explicit form the development of our theoretical and practical thinking. We must force ourselves to be as scientifically rigorous as possible; yet we must face the realization that our practice cannot wait for the orderly and slow development of

[1] This does not imply the advocacy of a new profession of community mental health to supersede the professions of psychiatry, psychology, social work, nursing, etc., but rather the advocation of a new specialized professional orientation to be added to the basic disciplines, that is, to lead to the development of *community mental health oriented* psychiatrists, psychologists, social workers, nurses, etc.

proved knowledge, and for a long time to come much of it must be based on hunches backed by evidence of a flimsy nature, and even upon artistic intuition. To make such matters explicit demands courage and scientific honesty, but it is a challenge we must face and share with our students.

Our experience at Harvard during the last five years has convinced us that it is already possible to develop a reasonably consistent approach to the problems of preventing mental disorder. We freely admit that many of our concepts are hazy and that the pattern of our system is not only not stable but is changing continually in line with our widening experience. However tentative many of our formulations may be, we do nevertheless believe that we can nowadays define explicitly sufficient of our subject so that it makes sense to us, to our students and to at least our friendly critics. Upon this developing body of theoretical and practical formulations our educational program is based.

OUTLINE OF PROGRAM

The program in its current form offers a 1- to 3-year course to psychiatrists who have completed their specialty training; to psychologists with some years' experience after the Ph.D.; and to senior, well-qualified social workers. Students are admitted for one, two or three years at the level of the program in keeping with their previous training and experience in public health and community mental health. The emphasis in the program so far has been placed on the first-year course, which leads to a master's degree in public health—either the Master of Public Health or the Master of Science in Hygiene with mental health as the area of major concentration. Approximately half to two-thirds of the student's time during the academic year is devoted to the study of traditional public health subjects, and the remainder is spent on theoretical and practical exercises in the mental health field. During the last five years 13 students have taken this course, and 2 have been accepted for the coming year.

The second- and third-year courses take the form of a residency program at one or more of the field stations of the mental health section. In the field station the student undertakes increasing responsibility, under supervision, for theoretical or practical work in research or service within the framework of its ongoing activities. In addition to collaborative work with the faculty team the student usually carries out one or more projects of his own and is responsible for writing reports on these. The residency program is designed to help fulfill the requirements of the doctoral program at the School of Public Health and candidates who choose to do so may work towards a Doctor of Public Health or a Doctor of Science in Hygiene degree. The residency program has been developed only during the last two years, and so far three students have completed one year, one student is currently in his second year, and two have been accepted for the first year of a doctoral program.

In addition to the master's and residency programs we offer opportunities for senior psychiatrists to come for three to six months as fellows to gain some understanding of the community mental health field. So far we have had two colleagues from overseas working with us in this category, by arrangement with the World Health Organization.

Our program also includes two other endeavors. We collaborate with the department of psychiatry of Harvard Medical School at the Massachusetts General Hospital in a 1-year training program in com-

munity mental health, which is offered to 3rd- or 4th-year psychiatric residents; to psychologists who are just about to get their Ph.D. or have recently graduated; and to social workers with several years of experience. This program is designed to give younger workers an opportunity to learn the rudiments of community mental health, and hopefully to interest some in continuing for more advanced training in this field.

The second of our supplementary programs plays a significant role in our general work. We have accepted responsibility for the in-service training in mental health consultation of selected members of staff of the division of mental hygiene of the Massachusetts Department of Mental Health. These include psychiatrists, clinical psychologists and psychiatric social workers, who attend regularly throughout the year one of two weekly seminars held at our central field station. During the last four years about 50 students have participated. Each worker attends seminars for two or three years, and during this period has an opportunity to learn the theories of community organization and mental health consultation and to participate actively in discussions of current consultation cases from his own or his colleagues' practice. In these seminars there is the possibility of a fruitful interchange between the university faculty members who are developing their systems of theory and practice on the basis of intensive studies in special field stations and the ordinary community mental health practitioners from the field. The seminar members operate from 16 regional mental health centers covering the whole of Massachusetts, and among them they encompass a wide variety of community experience. Insights which are developed at the university center are fed into the seminar and can immediately be tried out on a wide scale under differing field conditions. The seminar members constantly feed back into the discussions the results of their endeavors, and this rich empirical experience serves to correct and modify the formulations of their teachers. Not infrequently insights have been developed during the seminar discussions which have illuminated and enriched intensive studies on mental health consultation conducted at the university center.

FACULTY AND FACILITIES

The Harvard School of Public Health is one of six privately endowed institutions in the United States which are primarily devoted to graduate education in public health. The school operates as an independent unit of Harvard University in close association with the faculty of the College of Arts and Sciences, the Graduate School of Education, the Medical School, Dental School, and various Harvard hospitals. It provides instruction for a variety of students from this country and overseas who are seeking a career in one or more of the three principal areas of public health activities: teaching, research and administration. Its faculty is organized in the ten major departments of biostatistics, epidemiology, industrial hygiene, maternal and child health, microbiology, nutrition, physiology, public health practice, sanitary engineering and tropical public health. A number of interdepartmental courses are offered, and students may also take in other departments of Harvard University such courses as social sciences, public administration, business administration and medical sciences.

Our mental health section is located within the Department of Public Health Practice and has particularly close links also with the Department of Maternal and

Child Health. Our teaching staff includes 8 full-time members—3 psychiatrists, a clinical psychologist, a sociologist, an anthropologist, a social worker and a public health mental health nurse; and 10 part-time members—4 psychiatrists, 3 clinical psychologists, a sociologist, a social psychologist and a mental health administrator.

Our full-time staff is based in our principal field training station, the Harvard Family Guidance Center, which is situated close to the main buildings of the school in the Whittier Street Health Center of the Boston Health Department, with which our section maintains an active collaboration. The part-time members are based in a variety of institutions which carry out research and teaching and offer service in the mental health field and which are closely linked with the activities of the section, mainly through the provision of field training possibilities to our community mental health students and also to other students at the school.

All members of our staff participate in teaching theoretical and practical courses at the school, both within the mental health section and also as an integral part of the courses provided by the Departments of Public Health Practice, Maternal and Child Health, and Epidemiology. Their primary contribution to the education of students of community mental health lies, however, in their operation as staff members of the various field stations, where our specialty training is concentrated.

We believe that specialist training in community mental health is best carried out in centers where the student can increase his knowledge through active participation in selected phases of the ongoing work. To provide opportunities for students to have a varied and rich experience and to cater to a diversity of individual needs dependent on different background experience and future career interests, we believe that a university center must be linked with a number of such field stations of different types. We have accordingly spent much time and effort over the last five years in arranging for the provision of such field training facilities, and today our task is almost completed. Each of our field stations is directed by one of our faculty members and includes on its staff other members of our faculty who are responsible for some particular project in which we are interested for training purposes. When one of our students is assigned to a field station, he works directly under the supervision of one of these faculty members, who maintains close and regular liaison with our core teaching group at the school. Although each of the field stations differs in important respects from the others, they all have in common the characteristics of placing major emphasis in their work on the community approach to preventive psychiatry in line with the prevailing philosophy of our mental health section, and they are all oriented towards the incorporation of research into their service activities.

I feel that the best way of giving you a concrete impression of this aspect of our program is to provide a brief description of the organization and activities of each of these field stations, which at present number six.

Our main field station, as mentioned previously, is the Whittier Street Family Guidance Center. This is directly administered by our section, with finances derived currently from the Commonwealth Fund and the National Institute of Mental Health. The unit has till now taken the form of a demonstration project to explore how a multidisciplinary team of mental health workers can establish and maintain collaborative working relationships with

the public health workers in a city health center with the object of studying fundamental aspects of the etiology of mental disorders which have a bearing on prevention, and of developing and evaluating techniques whereby this knowledge may be applied in practice by health and welfare workers as well as by mental health specialists. The main etiological studies so far have concentrated upon the response of families to the crisis of the birth of a premature baby. The health center deals with a population of about 100,000 living in a predominantly lower-class, racially mixed, congested part of Boston, and the families studied have been a stratified sample drawn from this area. It is envisaged that based upon the results of these and subsequent studies techniques of preventive intervention will be developed for helping families manage the crisis of premature birth and other hazardous events in ways which will be conducive to the mental health of their members.

Meanwhile, the main service provided by the center has been a consultation service to the public health nurses in the building to help them deal with the mental health problems encountered in their daily work. The processes involved in building up this working partnership are being studied, and methods are beginning to be worked out for evaluating the effect of these activities on the attitudes and performance of the nurses in contributing to the mental health of their ordinary patients. The demonstrated worth of this mental health consultation to the public health workers has already led to the recent establishment by the Boston Health Department of a city-wide program which is based upon the principles and methods developed in the Whittier Street Center.

The Family Guidance Center has proved an ideal training station for our students. They have participated in most phases of its activities, and many of them have made a very effective contribution to specific parts of its program while themselves benefiting from the opportunity to enlarge their theoretical and practical knowledge. Particularly beneficial has been the opportunity to experience some of the group dynamic problems of multidisciplinary team collaboration and to evaluate some of the ways of dealing with these, as well as to learn in concrete situations the kind of questions which can be effectively handled by different professional disciplines and the characteristic working approaches of each of these. This has proved the most effective opportunity for students to learn how to acquire and adapt the statistical and other research techniques of the social scientists in enlarging their own professional armamentarium.

Our plans for the future of this center, assuming we can obtain the necessary financial backing, are to continue the present line of development in the form of a permanent unit which will be called the Harvard Laboratory of Community Mental Health. This will provide a stable group of university workers who will continue the present integrated approach to pioneering service, research and training, which can be kept constantly geared to current needs in the community mental health field.

Our second field station is the Wellesley Human Relations Service. This is our oldest center and was started ten years ago by Erich Lindemann when he founded our section. It was staffed and administered directly by the section, with the financial support of the Grant Foundation during the first five years of its existence. Since then it has become a local community-administered unit, although it retains its link to our school by virtue of the fact

that its senior staff members hold appointments in our section. It is situated about seven miles from the school and is much used by our students. Its activities complement very nicely those of the Whittier Street center. The latter is focused on intensive collaboration with one single agency, the health department, and through this channel deals with an urban lower-class population. Wellesley's activities are integrated into all aspects of the community life of a suburban middle-class area which is small and compact enough so that it has been possible to build up relationships with most of its community agencies. Whereas the Whittier Street Center is fundamentally a research unit, Wellesley's activities are based upon preventive psychiatric service, the responsibility for which it has undertaken on behalf of the community. The main learning opportunities it affords our students are in the fields of practice—mental health consultation, community organization and preventive intervention—but as in all our field stations, each of these areas has from time to time research projects linked with them.

Our third field station is the South Shore Guidance Center at Quincy, Mass. This is a community mental health center administered by the Massachusetts Department of Mental Health in collaboration with a local voluntary organization of citizens, and financed partly from State funds, partly from local tax funds and partly through the Community Chest. It has developed from a long established child guidance clinic, the activities of which have been broadened to cater to the mental health needs of a mixed urban and rural population of 200,000, situated seven to ten miles from Boston. It has excellent collaborative relationships with the local courts, police and school systems, and through these connections it has been successful in organizing two epidemiological research projects—one on the incidence and prevalence of acute and chronic emotional disorders among the children of the area, together with a study of preventive intervention techniques for dealing with the acute crisis situations identified in the study; and a second project to develop a psycho-bio-social classification system of juvenile delinquents, which will be related to prognosis and thus clarify problems of disposal.

The director and three of the senior staff members of the center are on our section faculty. Our students have made use of its facilities, particularly the research projects, and have obtained supervised experience in mental health consultation in one of its five affiliated school systems.

Our fourth field station is the head office of the division of mental hygiene of the Massachusetts Department of Mental Health, in Boston. The director and his two associates are members of our faculty, and they provide opportunities for our students to spend some time learning at first hand some of the problems of administration and community organization at the state level.

We are at present exploring the possibility of supplementing these opportunities for learning community mental health administration by making use of appropriate facilities in California. This summer one of our students, a psychiatrist from Portugal, spent two months in California under the supervision of Dr. Schwartz and Dr. Hume learning something about the state's administrative problems and how they are being handled. It may be that through the good offices of these state officials, we shall shortly be able to add California to our list of field stations.

Our fifth field station is the Community

Mental Health Service of the department of psychiatry at the Massachusetts General Hospital. This deals with the problems of the neighborhood immediately surrounding the hospital, and its activities are currently focused mainly on a study of the mental health effects of urban relocation. It happens that the major portion of the population of that area is in the process of being moved to other parts of the city in a slum clearance program. We have organized a research project under the joint direction of Erich Lindemann and me, and financed by the National Institute of Mental Health, to study the psychological effects of this community crisis. Some of our students have already made valuable use of the learning opportunities provided by this project.

Our last field station is the Greater Lawrence Guidance Center. This is a community mental health center administered by the state in partnership with a local citizens' voluntary organization. It caters to the needs of five adjoining towns with an aggregate population of 100,000 which are situated about 26 miles from Boston. Its special characteristics derive from the fact that it lies so far away from Boston, that its citizens turn much more for service to local agencies than people living within easier reach of the metropolis, and from the associated fact that its core staff is composed of local residents who are themselves, as individuals, well integrated into their community. The latter factor provides opportunities for rich insights into the life of the community and also leads to special personal problems for staff members who have some interesting difficulties in differentiating their professional and private roles. This center is linked to Harvard by the director's being a member of the faculty of our section and by my acting as its psychiatric consultant. It is too far removed from our school for more than occasional visits by our students, but its main usefulness as a learning opportunity lies in the fact that once every two weeks its entire professional staff comes into Boston for a 2-hour consultation session with me at the Whittier Street Center. Our students are invited to these sessions, and since the meetings are organized to deal with any problem currently arousing staff concern an opportunity is thus provided not only for our students to observe consultant and consultee techniques but also for them to obtain a firsthand view of a wide variety of the problems which beset the practitioner in the community mental health field. Like the in-service training sessions for the state workers, these meetings help to counteract any "ivory tower" tendencies of our faculty, and they help to keep us and our students in touch with the facts of life.

THE CURRICULUM OF THE FIRST-YEAR COURSE

Until this year our community mental health students were about equally divided as to whether they sought a M.P.H. or S.M. Hy. degree at the end of the academic year. The regulations at Harvard have now been changed to assure that students working for the M.P.H. degree obtain a more comprehensive and deeper understanding of general public health subjects than in the past. Twenty-five out of the 40 credit units for the degree are now to be obtained from required courses covering the whole field of public health theory and practice. The scheduling of these courses is such that our students would have difficulty in including their studies in mental health and immediately relevant

public health subjects. It is therefore likely that from now on our students will prefer to take the S.M. Hy. degree, which our school has specifically designed for candidates who wish to specialize in a specific category of public health theory or practice. This program offers a very flexible curriculum which can be tailored to meet individual requirements, and has only one required course.

The fundamental issue in planning the curriculum for a community mental health specialist at our school is to determine the most appropriate ratio of general public health and specific mental health subjects which must be fitted into a single academic year. Our experience so far leads us to the conclusion that although it is feasible to develop a community approach and a professional identity as a public health man within this space of time it is not possible to equip the student with sufficient community mental health skills so that on graduation he can expect to work at a high level as an independent specialist. We therefore see this first-year course as laying a foundation for specialization. Upon this foundation must subsequently be built the specialist structure, which can be acquired either through the formal training process we provide during the second- and third-year program or through an autodidactic or supervised learning experience in a suitable job situation.

It is difficult to describe briefly the curriculum of the first year because it has varied a good deal according to the needs of individual students, and it has been altering in line with changes in our thinking and with the developing educational policies of our school. I am the faculty adviser for each of our community mental health students, and perhaps an appropriate way to give you a concrete idea of an average curriculum would be to envisage the advice I will probably offer the two psychiatrists whose course I will be helping to plan during the coming year.

They will probably both elect to take the S.M. Hy. degree, and this will mean that their only required course will be biostatistics and epidemiology, an integrated course designed to present the fundamentals of the two disciplines essential to the investigation of problems of health and disease at a community level. Biostatistical techniques are taught with special reference to demography, and a small number of diseases are covered in detail by means of lectures, seminars and laboratory exercises to show the methods by which our present level of knowledge has been reached, and to illustrate the principles of epidemiology.

In addition, I will probably advise them to take the following four courses taught by my public health colleagues:

Principles of Public Health Practice—in which the principles of administrative organization, personnel management, financing of health services, and public health law are presented as the basis of public health administration.

The Organization and Administration of Health Agencies—in which the practical application of these principles is developed through problem-centered discussions and in which each student is assigned to a small group to study a broad and current public health problem with the help of a seminar leader and various health specialists.

Factors in Health and Disease—which covers essential aspects of economic geography and nutrition (for example, agricultural practices and their influence on public health) and the relation between

environment and health (the importance of natural hazards, climate, radiation, smog, etc.).

Principles Basic to the Practice of Maternal and Child Health—which includes attention to the physical, social and emotional characteristics and needs of mothers and children, the principles of planning and operating maternal and child health programs, and criteria and methods for evaluating them.

We have a well developed social science teaching program at our school, and from this I will advise the students to choose these courses:

The Human Community—a course which deals with demography, social and cultural characteristics of human populations, the organization and behavior of human communities and their relationship to the environment, providing a knowledge of human populations, interpersonal relationships and social organization in preparation for the study of public health.

Research Methods in Community Health—a problem-centered seminar course which covers such methods and techniques as research design, surveys, case and longitudinal studies, as well as relevant statistical techniques, methods of constructing and administering interviews, and other methods of data collection and analysis.

Health and Illness in Cross-Cultural Perspective—a course given jointly with Harvard Department of Social Relations in the form of seminar discussions of specific studies of a socio-medical nature by experts who have practiced or studied health problems in a variety of cultures.

To this list I will add a course which is presented by the department of epidemiology, and part of which I myself teach, called Ecology and Epidemiology of Chronic and Non-Infectious Diseases. This course is concerned with the ecological study of such diseases and disabilities as mental disorders, accidents and metabolic, neoplastic and degenerative diseases. In addition, particular attention is paid to the diverse effects on health which appear to be connected with patterns of human experience in such areas as parent-child relationships, dietary practice or social class.

Over the academic year these courses add up to 32 credit units, and I envisage that our students will perhaps accept the idea of taking almost the complete list, possibly to a total of about 28 units. This will leave them with about 14 or 15 credit units to be devoted to mental health topics. In addition to the portion of the course on the Epidemiology of Non-Infectious Disease devoted to mental disorders, they will probably wish to take the other two mental health courses offered to their non-specialist colleagues—Group Dynamics and The Control of Mental Disorders. They will take these courses not so much because they will expect to learn much new content, but to participate with their public health student colleagues in a learning situation focused on mental health matters. This will allow them to watch critically how the material is presented and to consider and discuss how the class reacts to various topics and methods of presentation. In the past our students have learned a great deal from these observations and from subsequent discussions of the problems involved in communicating mental health content to non-specialists.

These discussions take place in a specialist mental health tutorial which I hold weekly for two hours throughout the year and which has proved to be the focal point of our specialist teaching. These meetings have been largely unstructured or else planned on an *ad hoc* basis according to

the current interests of the students or myself. They have provided an opportunity to integrate the concepts derived from the public health courses with our ideas on community mental health and to have problem-centered discussions which allow the development of a continuous thread of basic principles from which a coherently patterned philosophy gradually emerges in the minds of the group members. These discussions have dealt with questions as diverse as the relationship of religion and psychiatry, group dynamics problems of interdisciplinary collaboration, the advantages and disadvantages of separate state departments of mental health and public health, research strategy in the community field, the merits and demerits of supplementary private practice for the full-time community health worker, principles and techniques in establishing a new mental health unit in a health department, and so on.

In addition to their active participation in the discussions from week to week, students have been required to choose specific assignments during the year to prepare semi-formal presentations to the group after reviewing the literature and consulting documentary sources. These presentations have covered such topics as the public health aspects of drug addiction, comparison of New York and California community mental health legislation, changes in incidence and prevalence of mental disorders over time as indicated by census figures, etc.

The remainder of the specialist learning opportunities offered to the students is derived from their participation in the practical supervised exercises at the field stations and from the seminars on mental health consultation and community organization which we hold at the Whittier Street Center.

In the past it has been possible for the S.M. Hy. students to spend an average of ten hours a week throughout the academic year at one or more of the field stations. In addition, most students have spent two whole weeks full-time on field work between the semesters, and some students have spent two to three months full-time in the field after the academic year ends early in June.

The kind of exercises provided are specifically designed to cater to the students' individual interests and needs. All students are provided with an opportunity to learn the practice of mental health consultation in a school system or a health department under the supervision of an experienced consultant. In addition, each student chooses a major field work project for his year's work. These projects are circumscribed aspects of the work of one of the field stations and usually have a research aspect, in the supervision of which we make full use of the assistance of the social scientists on our team.

THE SECOND- AND THIRD-YEAR COURSES

Space does not permit me to do more than refer briefly to our residency program. Our advanced students spend little of their time on formally organized course work, although some of them have in the past taken courses at the school and elsewhere at Harvard. They are mainly occupied in working on research projects and in acquiring and consolidating the skills of mental health consultation, community organization and preventive intervention by operating for various periods in field stations of their choice.

FOLLOW-UP AND EVALUATION

We have made a point of constantly soliciting the reactions of our students to the

content and method of our instruction, and we have used their opinions to guide us in refining and modifying our program. With the help of a special grant from the National Institute of Mental Health we have also developed on active follow-up contact with our graduates, to learn the nature of the problems which face them in their jobs, and how far our educational program has fitted them to deal with these problems. During the coming year we hope to hold a 2-day conference which will be attended by most of our graduates and which we hope will lead to some constructive suggestions for further improvements in our program.

We offer a certain amount of continuing consultation to our graduates on their current work problems. In certain cases where occasional personal contact has been possible this has been very welcome and has helped to foster further professional growth and development on the job and to counter the sense of isolation in men holding responsible key positions in which they are operating on their own and in which they are subjected to powerful and complicated field pressures. We believe that such follow-up consultation relationships are of value to both parties. If managed correctly, they prolong the benefit of the teacher-student relationship in a situation of lessening dependency and serve to consolidate the gains of the academic program. On the other side, they help the educator to remain constantly abreast of happenings in distant areas of the field so that he can keep his teaching program up-to-date. By facing him with examples of the inescapable complexities of community mental health practice they help preserve in him that humility which is the basic element of his role.

DAVID ABRAHAMSEN, M.D.

Mental hygiene services in private schools

In 1950 a research project was started in the department of psychiatry at Columbia University to ascertain what kind of child guidance clinics and mental health facilities exist in public and private elementary and secondary schools in the United States. The preliminary results of the findings in public schools were published in 1955.[1]

We are giving here the highlights of our findings in private schools.

To ascertain the quantity and quality of child guidance clinics and mental health facilities in private schools (independent schools)[2] in the United States, 380 sets of questionnaires were used to acquire information from selected private schools[3] in each of the 48 states. In cases where the information on the questionnaire was incomplete, personal interviews with the head of the school or its representative were usually undertaken.

The first purpose of the questionnaire was to obtain data about the number of children recognized as emotionally disturbed, socially delinquent or manifesting both emotional disturbances and delinquent behavior.

The second purpose was to assess the quantity and quality of the resources at present available for dealing with such

Dr. Abrahamsen is a consultant to the New York State Department of Mental Hygiene and a visiting professor of the graduate faculty of the New School for Social Research.

[1] *Journal of Pediatrics*, 46(1, 1955), 107–18.

[2] Not all private schools are to be considered independent schools.

[3] Among these were some parochial schools.

personality problems in children, the concepts of mental hygiene in the schools, and the resources believed by school officials to be essential for helping children.

The third purpose was to develop a concrete program of child guidance clinics in private schools.

Of the private schools 32%, with 32,909 children, returned the questionnaires, which is somewhat lower than the 35% returned by the public schools.

FINDINGS

The percentage of emotionally disturbed children in private schools ranges between 0 and 80. The range is greater than in the public schools, where the percentage of emotionally disturbed children ranges between 0.6 and 60. On the average, the percentage of emotionally disturbed children in the private schools is 11.7, while the percentage of such children in the public schools is 10.

In 57% of the private schools mental hygiene problems are not discussed in the classroom. In the public schools the corresponding figure is 80%.

In 24% of the private schools mental hygiene personnel give lectures to the children. This takes place in only 20% of the public schools. It is noteworthy, though, that in both private and public schools less than half of the mental hygiene personnel are specialists (that is, psychiatrists, psychologists or psychiatric social workers). This indicates that about 90% of the private schools do not provide such a service by trained mental hygiene personnel.

On the average the private schools reported that 66.6% of their need for both professional and non-professional mental hygiene staff[4] is met, while the public schools reported that only 18.4% of their need is met.

Thirty-six percent of the private schools do not have any mental hygiene services whatsoever available for emotionally disturbed children, while 17% of the public schools do not have these services available.

The reasons why 36% of the private schools do not have any mental hygiene services available are many:

- Thirty-eight schools say they refer emotionally disturbed children to private sources of help.
- Six refer emotionally disturbed children to university sources.
- One school feels the community is not ready.
- Another reports that many children of psychiatrists and doctors are in the school.
- Five schools say they have limited funds.
- Six feel that all their teachers are guidance workers.
- Two report they do not take care of mental health problems.
- Fifteen say they do not take any disturbed children.
- One parochial school said a mental health program could not help emotionally disturbed children.
- One school said it would be unnecessary and unwise to have mental health personnel in the school.
- Another said it did not wish to disturb the mental serenity of the pupils.

[4] To clarify what is meant by professional and non-professional mental hygiene staff in this study, the former comprises the child guidance unit, the psychiatrist, the psychologist, the psychiatric social worker and the school social worker, while the latter comprises the counseling teacher, the school counselor, the guidance counselor and others.

- Another said it is not convenient to have mental hygiene personnel in the school.

While, generally speaking, the public schools (figured on the basis of 2,500,000 children) indicated that they have only one psychiatrist for every 50,000 children, one psychologist for every 11,000, one psychiatric social worker for every 38,500, the private schools (figured on the basis of 32,000 children) have one psychiatrist for every 2,500 children, one psychologist for every 950, and one psychiatric social worker for every 11,000.

The greatest number of emotionally disturbed children, 16% on the average, were found in schools having more than 100 and fewer than 300 pupils. About 13% of emotionally disturbed children were found in schools having more than 500 pupils, while only 3.6% were found in schools having between 400 and 500 children. If any conclusion can be drawn from these statistics, it is that the best private schools (that is, those having the least number of emotionally disturbed children) are those which have between 400 and 500 pupils. Such a conclusion is wrought with faults, however, since the level of mental hygiene in a school depends to a large extent upon other factors, such as how carefully screened the children are before admission, the emotional climate in the school, the recreational facilities available and, above all, the type of emotional relationship existing between the teachers and the children.

In studying mental hygiene personnel in private schools we find in the child guidance and psychiatric professions a pronounced disparity between available facilities and what the school authorities consider necessary to meet their needs. Although the disparity is not so pronounced for the other groups (psychologists, psychiatric social workers, counseling teachers, school counselors, guidance counselors and others), what exists definitely falls short of what is needed in all other areas except one, namely, the school social worker, where the need and the available personnel are exactly equal.

The most frequent category listed by private and public schools is the counseling teacher, though the work he carries out is rather undefined. This category is considered by many school administrators as a professional discipline on the same level as the disciplines of the psychiatric team. (As we know, the psychiatric team consists of a psychiatrist, a psychologist and a psychiatric social worker. Sometimes a school social worker is substituted for a psychiatric social worker.) As we found in public schools, many private schools use the counseling teacher as a mental health resource. As a matter of fact, these counseling teachers by and large have little or no training in psychodynamics or therapy techniques. Only where mental hygiene work is supervised by a part- or full-time psychiatrist have we found some counseling teachers who are qualified to help deal in a superficial way with emotionally disturbed children. It is unfortunate that the basic orientation of the counseling teachers is more or less that of the teacher-training schools, which frequently are more interested in academic achievement than in emotional growth.

It is interesting to note the relationship between the personnel needed and the personnel which actually exists in the private schools. Take the psychiatric team, for example, in this case also including school social workers. We find that three times as many child guidance units are needed as exist. The actual picture is even more dismal in that most of the

clinics do not fulfill the standards we have for a child guidance unit, which should consist of at least one part-time or full-time psychiatrist, one psychologist and one psychiatric social worker. Only in a few private schools throughout the United States do we find child guidance units which satisfy the regulation standards.

The need for school psychiatrists is almost three times as much as the supply. Psychologists are employed in a ratio closer to their need than are psychiatrists. Psychiatric social workers are required in a ratio of 5:3 above what the private schools have at present. There exist as many school social workers as are needed.

In comparing the public and private school systems in the United States as to the expressed need for different types of mental hygiene personnel, we see that there exists a greater discrepancy between needed and existing facilities in the public schools than in the private schools. Relatively the greatest need is for child guidance units, psychiatrists, psychiatric social workers and school social workers, while the need is fairly well-satisfied for psychologists, at least in the private schools. The relatively lower need for psychologists above and beyond the present supply in schools can be explained by the fact that in the past they played a much greater role in the educational system than did the other groups.

The public schools report a greater need, above and beyond what they already have, for more child guidance units, psychiatrists, psychologists and psychiatric social workers, relatively speaking, than do the private schools. The only need which is fully met is the one for school social workers in the private schools. The reason this need is not filled in the public school system may very well be that these schools usually would rather employ psychiatric social workers than school social workers, the role of the latter generally being less clearly defined. On the other hand, private schools apparently would rather employ school social workers—a group not so psychologically or dynamically oriented as are psychiatric social workers and generally requiring lower salaries.

Now let us note the percentage of need for mental hygiene personnel now being met in public and private schools. The sampling of public schools was taken from a large city in the East which recognizes the emotional well-being of the child as an important factor in furthering the educational process. When we compare the "professional" clinicians of the mental hygiene staff in private and public schools, we find that only 14.6% of the need for psychiatrists and psychological personnel is filled in the public schools, while in private schools 57.5% is filled. Where the non-clinicians of the mental hygiene staff are concerned, 22.2% of the need for personnel is satisfied in the public schools, while the private schools have 75.6% of their need supplied. When clinical and non-clinical staff members are combined, only 18.4% of the need for mental hygiene services is covered in public schools, while 66.6% is covered in private schools.

There are some private schools throughout the country, particularly in the East and West, that not only maintain high scholastic standards but also take care of the emotional and mental needs of their children to a large extent. These schools are very well aware of emotional disturbances in their pupils and offer psychiatric help. One such school in the Northeast which has about 400 pupils wrote the following:

"Head of school has had considerable training in mental health problems. As a result, girls are referred to psychiatrists for a survey of their needs for reasons that may

seem trivial to some schools. The Delaware program is used in two classes. A course in human relations under the direction of a man in that department at X University is given our seniors. A number of our teachers are being analyzed. We have a group of eight teachers in a course in group dynamics under the leadership of a psychiatrist. The X Association for Mental Hygiene held a 1-day institute at this school in September. In other words, our school has, I hope, one of the outstanding programs in this field of mental health."

One private school with an enrollment of between 200 and 300 pupils on the West Coast states that 40% of its children are emotionally disturbed. This school is indeed aware of the emotional problems of its pupils. Its comments follow:

"We send children to psychiatrists chosen by parents, but we should like to have one full-time psychiatrist and one psychologist on our staff. Although we do not have any seriously disturbed children, we still need expert counsel for *many* children and a thorough psychological study of *each one.* We have a thorough testing program; we send many children to psychiatrists for diagnosis and therapy, but we do not have these highly trained experts on our staff. We wish very much that we did have that guidance. Some day we hope that will be possible. Then, perhaps, we might help to meet the increasing need that is pressing in upon us by taking in more children who need special help."

One private school was very frank in its answer to us when we asked how many children have difficulties recognized to be of an emotional nature. The school's reply was: "One hundred percent (of a normal nature) at one time or another, varying in seriousness and in length of duration." Although this school recognizes that within normal limits all children have emotional problems, even from its frank answer it is difficult to see who decides the degree of seriousness of the emotional conditions of the pupils.

There are many private schools with very good reputations which are concerned about marks to a high degree, while the emotional equilibrium of the pupils seems secondary. Many private schools were more evasive in their attitudes and in their replies than were the public schools. It was obvious that some of the former disregarded the children's emotional and delinquent problems as if they did not exist. Even when there was strong evidence to the contrary, some of these schools denied they had children who were emotionally disturbed and delinquent or just emotionally disturbed. One receives the impression that most of the private schools appeared reluctant to indicate a need for additional mental hygiene personnel. Instead, they all stated they needed only as many as they had at the present time.

One basic reason for this is that they cannot afford, being constantly and completely dependent upon private funds, to expose whatever weaknesses they may have to the public. For that reason also some private schools have stringent admission rules. Some schools (15 in all) do not admit children who show signs of emotional disturbances. Other private schools are quite liberal in their admission policies. Some even seem to like to accept pupils with personality problems. This is particularly true of private schools located in or near big cities, where psychiatric help is more available than in rural areas.

Although the figures indicate that in many spheres the private schools do not seem to need much more mental hygiene personnel than they have at present in

their schools, further studies of our statistics and follow-up information indicate that there is a greater need than they seem to admit. The exact responses to our questionnaires by the heads of the private schools were tabulated, and where there seemed to be a discrepancy with other data we asked for further information. When this information was given, it frequently turned out that the private schools did not seem to have as much mental hygiene personnel or as many facilities available as originally indicated.

Statistics, however, good as they may be, are inadequate when it comes to depicting the human side of mental hygiene problems in the schools. Many private schools expressed a great deal of interest in our research and asked for help, while others showed a lack of understanding of the situation and even indifference to our inquires.

For instance, to our question as to whether there are any psychiatric services available one school in the Northeast commented: "We do not wish to disturb the mental serenity of our pupils by suggesting psychiatric problems. We do not enroll pupils who are definite psychiatric problems." When asked how many parents are interviewed about the children's emotional problems, this same school answered: "We discuss the children's condition with all parents whenever there is an opportunity, whether they are normal or otherwise."

A small private school in the Southwest answered the question of whether psychiatric services are available as follows: "We do not take psychiatric cases knowingly. So very few of our children have such a difficulty, and then it is not great." The same school reported that it needed and had a psychiatrist, a psychologist and a counseling teacher for the children. In view of the statements that the school does not knowingly take on any psychiatric cases and that few of its children have psychiatric difficulties, it seems rather encouraging that this school has as much help as it does—unless, of course, it is underestimating its students' needs.

One school in the East states that it does not need any psychiatric advice, although it admits having some children who are emotionally disturbed. On the other hand, a school in the Northwest which has between 100 and 200 students writes: ". . . while we do not have any person on the faculty whose position is dedicated specifically to mental health problems, we work very closely with a regular psychiatrist, who is especially able in his treatment of emotional problems." The letter goes on to state that the school has had some students who needed help beyond what could be offered by the school and also some who were "beyond our scope." They were sent to a school able to handle them.

Another school in the Northwest with an enrollment of 200 boys writes:

"We rarely have a delinquent boy in school, but, if course, we have students with emotional difficulties. These difficulties stem from adolescence, from poor home environments, or from failure to adjust socially to the school community. While we acknowledge the importance of solving these problems and of realizing the effect they may have upon a boy's ability to make the most of his youthful opportunities, we nevertheless will rely largely upon the counsel and advice of our teachers to help a boy solve his personal and emotional difficulties. There are so many opportunities for a teacher to discuss with an individual boy any special problems which he may be facing that we have come to feel that in the vast majority of cases our method is an effective one. . . . It is important to

point out that we do not hesitate to seek psychiatric advice from outside the school whenever it is clear that we are not helping a particular boy to meet his problems successfully . . .

"Considerable attention is given to religious education and to Christian worship. We have on occasions visiting preachers who are available for counseling purposes. Recently we had just this experience and with the most fruitful kind of result; because he came in from the outside and was a man for whom they had respect, they talked to him individually and in considerable numbers."

Although this same school notes that it regularly invites competent psychiatrists and educational counselors, not only to talk with its teachers about mental health techniques but also to discuss some specific student, the school did not feel inclined to fill out a simple questionnaire.

One school from the Middle West writes: "Our teachers, being trained as religious teachers, and the preacher are adequate to handle our problems (mental health problems)."

Characteristic is what a large school in the Northeast which has between 400 and 500 students states:

"We don't discuss mental health problems, nor do we have any mental hygiene talks with our boys.

"With a large selective group we have no delinquencies nor boys who present any problems other than those common to adolescence. If, during the time they are here, a boy develops an emotional problem, Mr. X and I talk with the boy and if necessary later with a doctor and the parents. In general, however, the few cases that develop are those which Mr. X and I can handle."

We find a similar answer from another school which has about 350 pupils, one with which we have been in touch repeatedly:

"We have no students who even approach delinquency but plenty who have emotional difficulties which require careful handling. Out of 350 pupils in the school there are four who show obvious and serious emotional difficulties and 19 who show danger signs to teachers, though they may not be recognized as such to parents. And there may be no cause for alarm if the girls can have the right help and treatment from teachers and companions."

Such a statement comes from a school which apparently has easy access to psychiatric and psychological help but which will rely upon its own teachers to solve problems which most decidedly belong to the province of the psychiatrist.

One recurring finding in our research on private schools is that practically none of them admits that it has any delinquent children (that is, children who are unduly absent or who are involved in stealing, lying or vandalism). Yet many practicing psychiatrists have pupils from private schools in treatment who have been involved in delinquent or antisocial activities. It is alarming that most private schools do not admit that some of their students have delinquency problems. When a child, for any number of reasons, should fail to become emotionally secure, a failure which may lead to emotional disturbances, with or without delinquency, his school can be one of the best instruments for the prevention of these manifestations. No school, however, can help the child or his parents unless the school itself is aware of what is going on in the child's mind.

One of the grievances the private schools have against psychiatrists in general is that they do not seem to have a sufficient amount of understanding of the school program. Thus a school on the Eastern

seaboard which has between 300 and 400 pupils from kindergarten to twelfth grade states:

"There are 30 children who present unusual or overemphasized conditions (emotional difficulties). Before undertaking individual pupils, we try to determine how big a load the appropriate class can take. We never have room for pronounced deviates. We also insist on psychiatric assistance for disturbed children. I suppose we undertake about five new problems each year. We have found several psychiatrists in X City who are extremely knowing and helpful to children from 4 to 18. We have found none with sufficient understanding of schools and of the potential of schools for mental health to be of important value in recasting our program and approaches." After minimizing what psychiatry could do regarding mental health in schools, the school goes on: "I think we are on the way to convincement that a psychiatrist could help very much in our faculty meetings and could possibly be of real value in helping administration and staff to promote individual mental and emotional health."

It is regrettable that so few psychiatrists have taken an active part in promoting mental health in education. Psychiatry, which primarily deals with the diagnosis and treatment of the mentally and emotionally disturbed, has been slow in applying its knowledge to the field of education. My own experiences, having dealt in particular with one aspect of mental and emotional disturbances—namely, antisocial tendencies—have led me to believe that one important possibility in preventing these phenomena is to use our armaments in the field of education.

On the other hand, psychiatry must be careful not to convert the school into a clinic. As one school on the Eastern seaboard states:

"I know our general approach has been very effective in many instances. I think we are making progress in learning new ways of doing many things. On the other hand, I feel it is important that we are always very much aware of the limitations of any school in the psychiatric rehabilitation of students. The school should remain, in my opinion, an educational institution and in no sense become a clinic. But I believe at the present time that we could use a somewhat larger staff without running the risk of developing into something other than an institution primarily devoted to education in the usual sense. But even an expensive independent school must balance its budget."

It must be stated that even if all the private schools wanted to employ the needed psychiatric help, they most probably could not do so, either because there is not enough trained psychiatric personnel or because of lack of funds. More important than this, though, is the need for schools, private and public, to learn to recognize emotional difficulties in children and to see to it that a program of diagnosis within the school and treatment outside the school be implemented. When educators become aware of mental hygiene principles they will realize that the classroom can be a place where children can test out their own ideas of group living and be encouraged to work out their problems. If they fail to recognize these principles, the school will be a place where emotional or mental disturbances develop freely, bringing forth emotional maladjustments and delinquencies.

It is not sufficient for any school, private or public, to be concerned only with teaching the three R's. As I have stated on page 267 in my book *Who Are the Guilty, A Study of Education and Crime*, it is now time for the schools to start thinking about

the *fourth* R, "relationships," that is, "emotional relationships." It is essential that teachers learn to understand the emotional attitudes of their children, and it is essential for the healthy growth of these children that they learn about themselves and their feelings toward their teachers and toward their classmates. The time will come when an integrated synthesis of the curriculum of the three R's with mental hygiene principles will be established so that both personality growth and the educational process can be developed simultaneously. If a school is to benefit pupil and teacher alike, it will have to see to it that principles of mental hygiene be woven into the pattern of the curriculum. Although this may sound idealistic, it still will have to be the aim.

Teachers must learn that mental health concerns itself with all aspects of human behavior. It is true that while psychiatrists can learn from collaborating closely with educators, so too educators can learn from close association with psychiatrists.

SUMMARY

Relatively speaking, private schools show a greater number of emotionally disturbed children than do public schools, but the former have better access to psychiatric help, particularly because their children are of a higher economic status. With respect to mental hygiene facilities, public elementary and secondary schools do not compare favorably with private schools, though the latter too fall far short of their needs.

In many private schools the lack of mental health services results not only from a shortage of funds and psychiatric personnel but also from a rejection of the fact that all children have emotional problems to some extent and that it is the task and duty of the educator to discover and prevent the development of emotional and mental problems that interfere with the learning process in the classroom and with the emotional well-being of the pupil.

A child learns best when he is emotionally happy. It is this happiness that every educator, whether he is in a private or a public school, has to further.

ACKNOWLEDGMENTS

I express my thanks to Emanuel Hammer, Ph.D., for his assistance and to Irving Jacks, M.A., and Sidney Connell, M.S., for their help during the early stages of this research project.

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LUDWIG L. GEISMAR, PH.D.

Social functioning of the multi-problem family

In recent years the term "multi-problem family" has come into ever more frequent use to designate a phenomenon known to welfare organizations all over the country: the seriously disorganized family.

To the best of our knowledge the term was first used in 1948 in the St. Paul family unit report study. This was an account of problems and services—economic need, social maladjustment, ill health and recreation—carried out by local agencies in collaboration with Community Research Associates, Inc. As used in this study, the term referred to the presence of more than one of three problems in a family situation: economic dependency, social maladjustment and ill health.

As a term to designate a type of family which has long been a major concern to welfare agencies, the word "multi-problem" was sufficiently descriptive to identify readily the object it represented. As a theoretical and operational concept, however, it was in need of more precise definition.

The effort reported here to refine the concept of multi-problem family is part of an evaluation study undertaken by the research section of the Family Centered Project of St. Paul. A one-sentence characterization might label this a social work pilot project having the dual focus of developing methods of casework and processes

Mr. Geismar is research associate for the Family Centered Project of the Greater St. Paul Community Chest and Council. His paper is a revised version of a report to the 21st Groves Conference on Marriage and the Family, held April 14–16, 1958 in Washington, D. C.

of community organization, both designed to help the seriously disorganized family. Organizationally the project is an alliance of seven local agencies, public and private, which with the financial aid of the Hill Family Foundation and under the auspices of the Greater St. Paul Community Chest and Council joined hands in providing treatment for the hard-to-reach, disorganized families with children in clear and present danger.

This paper will discuss only one of the objectives of our research: The search for a method of appraising the behavior of multi-problem families. The need to develop a clear basis for the multi-problem concept was at the root of the evaluation study.

SOCIAL FUNCTIONING AS A CONCEPT FOR EVALUATING THE TOTAL FAMILY

The choice of method for evaluating families was indicated by the project's basic approach in serving them. Throughout treatment the family is viewed as an interacting group and the individual problems of members are seen and treated in their group context, that is, as affecting all the members of the family. Evaluation, it was felt, should likewise take account of the whole family rather than only of individuals or segments of the group.

The concept of social functioning was most appropriate for analyzing the behavior of the total family. Social functioning first of all was a concept which permitted us to relate the individual and collective behavior of family members to the tasks assigned to them, as it were, by society. This enabled us to evaluate family conduct on a scale of values which made measurement feasible to the extent that these "assigned tasks," known to the sociologist as role expectations, could be organized conceptually. Secondly, family-centered casework had focused on the social functioning of the family, and the concept had served the social worker in the project as a basis for gathering data for his social diagnostic study of families.

The concept of social role offered itself as a natural correlate of social functioning. Role represents the functioning of an individual within the context of a given situation and in relation to certain social norms called role expectations. Social role thus provides the link between the individual and the social system, for the roles of a person define his functioning in a network of roles and with a set of role expectations, both of which are parts of that system.

The utility of the concept of social functioning in our effort to define the multi-problem family lay in the fact that the conceptual scheme discussed here made it possible to view the behavior of family members in relation to a set of problems with which the larger group—in our case the local community—is concerned. To make this relationship more specific there is need to explore whether it is possible to identify a universe of social functions which are "assigned" to the families the project is serving.

THE PATTERN OF SOCIAL FUNCTIONING OF THE DISORGANIZED FAMILY

Prolonged experimentation—in collaboration with casework—with abstracting case records in terms of tentative categories of family functioning resulted in the establishment of a 9-category pattern which the caseworker found useful and which satisfied minimum criteria for statistical reliability. These will be referred to later on. Each category is composed of two to four subcategories, making a total of 26 subcategories of

functioning.[1] The 9-category pattern of social functioning comprises four areas—family relationships, child care and training, health practices, and household practices—which require role performance largely within the family group. Three areas of functioning—economic practices, social activities, and the use of community resources—refer to role-playing chiefly outside the family. An eighth area—called relationship to the family-centered worker—which likewise involves role performance outside the primary group, does not generally constitute one of the functions that are basic to the welfare of the American family. In the disorganized family under treatment, however, the relationship to the family-centered worker, who is in a primary helping position, becomes a major focus of family functioning.

All eight categories thus far enumerated represent an accounting of the manner in which socially "assigned" tasks—"assigned" or expected by the community—are carried out without major regard to who performs them. By contrast, a ninth category of functioning—individual behavior and adjustment—reflects the manner in which each family member performs his various social roles.

The 9-category pattern can hardly be considered a scheme which is adapted to any and all groups of families even in the urban American culture. Its theoretical and empirical basis is the socially disorganized family in a medium-sized community. Any categorization of functioning such as this must take full account of the focal areas in which family life is carried on. For a group of upper middle-class families, the category "political behavior" might well be such a focal area in family life. For the disorganized family such behavior, though expressed through voting, union membership and so on was not found to be sufficiently prominent to merit analysis as a major category. Political behavior, when present, could be dealt with under "use of community resources" and "social activities." "Relationship to the caseworker," by contrast, would hardly constitute a major focus for analysis in the functioning pattern of the American middle-class family.

The 9-fold categorization of social functioning opened the way for characterizing problematic or multi-problematic functioning of the family in analytic terms. Before this could be done, however, there was need to mark off the dimensions of functioning or malfunctioning in each of the nine categories designated. This proved to be the least objective and thus most problematic aspect of our evaluation procedure, because any attempt to mark out specific levels of adequacy of functioning in clearly defined areas of family functioning required the use of value judgments.

LEVELS OF SOCIAL FUNCTIONING

The social work discipline is no less guarded than the non-applied behavioral sciences in its use of value judgments in research. That which is inevitable in casework—the separate evaluation of the functioning of individual clients or client families—is viewed with serious reservations and apprehension when it is used in connection with groups of clients. It is suggested here that the standards of evaluation, which are implicit in the work with each individual family and determine such activities as case opening and closing, referrals and so on, form a basis for evaluating the functioning of groups of clients.

Family-centered and protective casework

[1] For example, the category "economic functioning" was subdivided into 1) source and adequacy of income, 2) job situation, and 3) money management.

with disorganized families justifies its intrusion into the affairs of resistive families because they are of real concern to the community, particularly in the way their children's welfare is being directly threatened. This factor of community concern, which is most clearly expressed in the violation of laws and ordinances (thus giving the community a clear right to step in), represents the content for a set of beginning definitions, as it were, in an evaluation of family functioning.

Community concern may be seen to comprise two related dimensions: the welfare of the family and the welfare of the entire community. These two are likely to coincide in the long run to the extent that the welfare of the family is ultimately linked with the welfare of the community. From a short-range point of view the two are not always in complete harmony, and professional casework is charged with the task of reconciling them.

To utilize the concept of community concern in evaluation, we had translated it into terms useful as bench marks in each of the nine categories of social functioning. Casework and research agreed that the construct "minimum level of functioning" or "marginal functioning" could serve as a central anchor point of a social functioning continuum with the extremes designated as adequate and inadequate functioning.

The concept of marginal functioning implies behavior in keeping with the minimum requirements for the protection of the community. These requirements include the maintenance of physical and mental health, the preservation of a degree of family unity which will provide a basis for socializing the children, the prevention of physical and emotional neglect of the young, of law violations, and of the family's otherwise becoming an undue burden upon the community. "Marginal functioning" refers to behavior barely above the level at which the community has a right to step in.

On this same scale of values "inadequate functioning" refers to behavior which clearly entitles the community to intervene because laws are being violated, the welfare of the community is threatened, and the well-being of the family is seriously jeopardized.

The main difficulty arises in connection with an effort to define "adequate functioning." It has been difficult to spell out definitions of adequate behavior in terms more positive than "the absence of law violations" and "functioning which is not inimical to the healthy physical and emotional development of family members especially the children." The danger in defining levels of adequate functioning is that of imposing the standards of middle-class culture. Nevertheless, our early attempts to define adequate functioning suggest that the caseworkers have, through their working identification and experience, acquired a more realistic set of expectations.

An illustration of the application of the three levels of functioning to "parent-child relationship," one of the four subcategories under "family relationships" might help clarify the nature of the task facing us in quantifying family functioning.

INADEQUATE FUNCTIONING

No affection shown between parents and children; great indifference or marked rejection of children or cruel treatment accorded to them; no respect shown for one another; no approval, recognition or encouragement shown to children. If parents show any concern at all, it takes the form of rank discrimination in favor of a few against the rest. Parent-child conflict extremely severe, being so serious as to constitute

neglect as legally defined or otherwise being a law violation.

MARGINAL FUNCTIONING

Affection between parents and children intermittent or weak or obscured by conflict. Parent's anger unpredictable and unrelated to specific conduct of children; family members played off against each other; marked favoritism with no attempt to compensate disadvantaged children; little mutual respect or concern for each other. Parents and children in frequent conflict. Danger to children potential rather than actual.

ADEQUATE FUNCTIONING

Affection shown between parents and children. Parents try always to be consistent in treatment of children. Children have sense of belonging, of emotional security. Children and parents show respect and mutual concern for each other. Parent-child conflict is minimal or restricted by consistent attention. Free communication and desire for harmony.

Our present scheme of quantitative evaluation utilizes the three levels of functioning as anchor points for a 7-point scale, with adequate and inadequate functioning representing the scale boundaries and marginal functioning the central scale position. To both sides of marginal functioning two additional scale points were designated whose content was not spelled out. These four scale positions indicate functioning slightly above or below the three defined anchor points. The continuum of social functioning then reads as follows: A plotting of a family's functioning by nine areas and 26 sub-areas yield what we called the family profile of social functioning.

Inadequate	Near inadequate	Sub-marginal	Marginal	Above marginal	Near adequate	Adequate
X	O	O	X	O	O	X

TESTING THE EVALUATION PROCEDURE

To test the reliability of this evaluation procedure we profiled the functioning at intake of 36 disorganized families receiving service by the Family Centered Project. These cases represented client families which had been opened in the project during 1954 and 1955 and had come up for review and evaluation by the casework supervisory staff between July 1956 and August 1957. Half of the cases were closed at the time of the case review; the other half remained open for further service. Every family had received no less than twelve months of intensive family-centered service. The average length of treatment was 29 months.

The 36 profiles were rated independently by three judges—two researchers and a caseworker supervisor.

They agreed (checked identical or adjacent points on the scale) on 83.4% of the items judged—32.5% were identical points, 50.9% were adjacent points. Only 3.1% of the ratings were three steps or half the scale range apart. These results were quite encouraging for they showed a reasonable reliability in judging by the social functioning scale is feasible.

The interrelationship among main categories of family functioning was tested by means of scale analysis. This test showed that the concept "social functioning of the family," as organized in this study, approximates a uni-dimensional scale,[2] the most frequently problematic items in the total pattern of functioning being "indi-

[2] Coefficient of reproducibility .75; coeffiicent of marginal reproducibility .48.

vidual behavior and adjustment" and "child care and training." By contrast, "economic practices" and "relationship to the family-centered caseworker" were found to be least problematic in the functioning of the disorganized families.

Social functioning requiring role performance chiefly within the family was significantly correlated with functioning in relation to friends, neighbors, agencies, communal institutions, etc.[3] This finding would suggest that data on the families' relationship to the community, more readily available to the agencies than is information on intra-family functioning, might be developed as indices of family disorganization.

The present method of evaluation allows us to differentiate among degrees and kinds of multi-problem family functioning, thereby infusing the concept "multi-problem family" with more specific meaning than had generally been attached to it in the past.

COMMENT

We have attempted here to report in brief on our efforts to set up a conceptual framework for defining and evaluating the functioning of the multi-problem family. The scheme is now being subjected to more extensive testing for reliability. Following this we intend to use it for an evaluation of the social functioning of the families which have been served in the project.

With this investment we have just begun to scratch the surface of research on the disorganized family. If we have succeeded here in sharpening our analytic focus and in pointing the way, for ourselves and for others, toward expanding and strengthening as yet meager theory about the social functioning of the multi-problem family, our efforts will have served the general purpose for which they were intended.

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[3] Chi square 22.28; 6 degrees of freedom; level of significance about .001.

H. MOROSS, M.B., B.S., D.P.H.

The community psychiatric service

A provisional blueprint of an integrated and comprehensive service based on the community and embracing rehabilitation and after-care

The South African National Council for Mental Health is engaged in developing a blueprint of an integrated and comprehensive service based on the community and embracing rehabilitation and aftercare. To date, a tentative scheme has been drawn up, based on the following premises:

The emotional impact and distress suffered by thousands of the population who are anxious and justifiably concerned about the welfare treatment and prospects of mentally afflicted relatives is so vast as to be incalculable, and is one of society's urgent concerns. With a view to providing some solution, the South African National Council for Mental Health established committees in 1955 to consider a blueprint for future mental health services in South Africa.

In formulating this "blueprint for an Integrated Psychiatric Service" to improve mental health, preliminary cognisance must first be taken of the following ideas:

Planning must be creative. It is not enough to reshuffle existing facilities for treating mental illness so that a resynthesis of the old components is produced. Thinking needs to be radical, and must question the underlying attitudes relative to services provided for the mentally ill. To an extent therefore this blueprint projects an ideal for the future which if not immediately of practical application may at least show a path which could be followed. In this connection, reference is briefly made to some of the principles adopted by the WHO Expert Committee on Mental Health.

Dr. Moross is medical superintendent of Tara Hospital in Johannesburg, South Africa.

In its second report the committee accepts the long-term principle of incorporating into public health work the promotion of mental health.

In its third report the WHO Committee deals with the place of the psychiatric hospital in the community, and concludes that, once the necessary minimum of "emergency psychiatric in-patient care" is provided, a great deal of attention should be devoted "to the development of extra-mural treatment facilities and other psychiatric facilities in the community." The committee deplores the fact that in the past too little attention had been given to the development of a real community mental health service in all parts of the world, and it recommends systematic employment of psychiatric hospital staff in extra-mural activities, of a therapeutic as well as of a preventive and educational nature.

Modern methods of treatment have, in most cases, eliminated prolonged periods of custodial care. In other words, with advancing techniques in medicine, the next phase of psychiatric evolution has come; and it now becomes possible to treat these patients, many of whom had previously perforce been allowed to lie and wait for spontaneous improvement or increasing dementia and deterioration. The concepts of isolation and other traditional attitudes towards mental illness that grew up in earlier days, and which were calculated to deal with a situation as it obtained then, rather than as it is now, have not completely disappeared; nor, for the most part, have physical location and structure of the mental hospital, away from the community, or locked doors and high walls.

It is now apparent that the newest phase in psychiatry is a complete reversal of all this. Previously, where patients were taken out of the community, we now try to put them right back into it. We believe today that mental illness should be dealt with and treated in this context—in the medium to which it arose, in relation to normal people and to the society in which the patient has always lived. For example, the period that a patient spends in hospital should be, not a retreat from the real world in which he broke down, but a model of it, as it were, that enables him to learn to deal with the problems that beset him in real life, in a controlled environment and with guidance and help. This example indicates how treatment and reintegration into the community can become one and the same thing.

In the third report of the WHO Expert Committee on Mental Health, in 1953, it is stated that large mental hospitals of the traditional type are not really suitable for carrying out such modern programmes of treatment; that everything should be done to discourage the building of more hospitals of this sort, inasmuch as the large mental hospital is liable to acquire an impersonal atmosphere. Furthermore, it recommends that such hospitals should be located in the natural population to be served, as the mental hospital remote from medical and population centres cannot properly serve its community. The need is for free interchange between patients, staff and society at all times.

It is a little-known fact that many mental patients can, with certain provisos, be cared for in their community, either in private homes or in some type of supervised accommodation. The provisos are (i) that the community must first accept this idea; (ii) that a psychiatric service can be taken into the homes and hostels, so that acute psychiatric illness can be taken care of immediately; and that those patients needing support and guidance can have it continuously from qualified staff.

Reputable authorities state that the number of psychiatric patients who are potential

public dangers and who need therefore to be handled in state mental hospitals is very low, no more than 5% to 10% of all patients. The others at present in mental hospitals all over the world, if given the services outlined in the blueprint, could be dealt with effectively within the community.

Furthermore, many of these mental patients are capable of at least limited employment whether in sheltered employment schemes or under the provisions of something like the Disabled Persons Employment Act of 1944 of the United Kingdom, although the introduction of such an act in South Africa would conceivably pose a number of problems. This employment would result in enormous saving to society.

One has only to know what is being done in Sweden, and particularly in Amsterdam, to recognize that these are not airy schemes but could, with careful planning, be put into actual practice.

Any scheme which will adequately cater for present-day needs has necessarily to examine critically the accepted and traditional ways of dealing with mental illness. Some of these have been rejected outright, such as isolation of the mentally ill, and have no place in our scheme; the rôle of the mental hospital is in process of change; other aspects depend on the accelerated evolution which cannot be long delayed owing to the increasing professional and public interest and pressure in these matters; the last group, however, where active and somewhat revolutionary changes are envisaged with emphasis on maximum treatment in the community, are fully accepted and incorporated in the blueprint.

The blueprint embraces many different agencies and institutions in the mental health field. It must be stated that these can and do exist only in larger, more developed, communities. Also that the available facilities will differ in other ways, from country to country, from urban to rural society, and so on.

Obviously, the application of such a scheme must allow for flexibility and adaptation. It is considered, however, that the underlying principles enumerated below should form the basis of any framework.

FUNDAMENTAL CONCEPTUAL FRAMEWORK

The vast bulk of the total endeavour with the mentally ill must be swung from the treatment and handling of established mental illness into the fields of promotive, preventive and early active treatment. This will involve a re-allocation of rôle to those institutions at present solely involved in the treatment of established illness.

Previously and at present, in most societies, mental illness in its various forms and with its manifold results tends to be taken care of by discrete units. These are often field and, at best, only partially interdesplit off from other agencies in the same pendent. Integration of all agents in a comprehensive scheme, conceived and executed on a sufficiently large scale to really effectively tackle the vast problem of mental illness, is necessary. The keyword of this new organisation is therefore "integration" —integration at all levels and of all agencies in the field. Administration and control must be coordinated and planning centralised, and the needs and functions of individual agents in the scheme subordinated to its overall requirements.

The treatment of the mentally ill must increasingly be done in the community, and moved away from the traditional isolation methods. Reconsideration of the total situation unshackled by traditional thinking and with present-day needs in mind leads us to the conclusion that the emphasis is

wrongly placed, and it is the psychiatric service in the community that should have the permanent role, and the other the more subsidiary one.

Another accepted and permeating concept that needs to be dispelled, again having to do with "discrete working" is splitting off of function. Hallowed by usage and entrenched by its operation, the idea is that prevention, detection, treatment and rehabilitation take place largely in separate areas, or, at best, are functions of separate organisations. For example, treatment and rehabilitation in general terms are usually conceived of as sequential, one following the other. It is recognised in the most enlightened quarters, however, that not only is the one a function of the other, but more pertinently rehabilitation should commence simultaneously with treatment. Efforts to adjust the patient to an appropriate functional level in his community on discharge should not commence when his psychiatric problems have diminished, but his rehabilitation should in fact constitute part of his therapy from the day he enters hospital. Socialisation, group techniques, psychotherapy, participation in milieu therapy and like procedures are as much directed at dealing with underlying causes of mental illness as in helping to equip the patient to deal efficiently with his surroundings, work, home, interpersonal relations, etc.

DETAILS OF THE BLUEPRINT

Many of the details of the blueprint are also laid out in the report of the fifth meeting of the WHO Expert Committee on Mental Health held in 1956.

Fundamentally, the plan is based on the idea that instead of having one large mental hospital which must perforce deal with every type of case and class of mental disorder, there should be smaller regional units, upon which the entire mental health programme will be based, and where intensive treatment will be given immediately to recoverable cases. Such small regional hospitals should be situated in the midst of the community and their aim should be rapid treatment and full-scale rehabilitation. Instead of being custodial in nature, the essential object of this regional mental health service would be early detection and treatment of mental disease, the prevention of chronicity and prevention of relapse. Its results would be a decreased need for mental hospital beds and custodial care.

In stressing the importance of such small psychiatric hospitals right in the community, it is not intended to imply that prevention in the mental health field must be based there exclusively. On the contrary, it is felt that other facilities should also be used and that, in some cases, they may be more effective than the psychiatric hospital.

Particularly, psychiatric out-patient departments and other ambulatory services undoubtedly have an outstanding significance. Experience has indeed shown that out-patient treatment is effective for many types of mental illness formerly thought to require in-patient care.

From the point of view of the health administration, out-patient arrangements are desirable because in-patient care is far more expensive; and it can be proved that the more out-patient facilities provided, the fewer hospital beds are needed. The out-patient clinics must be more than just consultation and treatment centres, however. One of their prime functions is as a centre from which numbers of clinical workers—doctors, nurses, social workers and health visitors—diverge into the community.

The psychiatric hospital service must be as "open" as possible. As pointed out in the

WHO fourth report, the legal formalities of admission and discharge should thus be reduced to a minimum.

To sum up, then, the central structure of this mental health service should be a relatively small, active, treatment unit which could be provided with the necessary out-patient facilities, and in some parts with mobile units and which, apart from its therapeutic duties, could also serve as a clearing house. Such a centre could exist as an independent unit having perhaps a day or a night hospital attached to it; it might be part of a general hospital; quite frequently it would be in close geographical or organisational contact with a long-stay unit destined to cater for the chronic cases.

As to the community integration of the service, no rigid pattern should be followed. Other medical and social organisations, both public and private, are often able to cope with these marginal problems, and it is therefore most important that they should be coordinated with the psychiatric service. Such organisations should include the clergy, educators, certain welfare societies and the voluntary mental health organisations which exist in most countries.

The blueprint also takes cognisance of the recommendations made by the Expert Committee on Mental Health of WHO relating to facilities for chronic patients.

The long-stay unit is a necessary complement of the central establishment with its predominant interest in active treatment and prevention. It is a serious mistake to entrust to it the main responsibility for the work to be carried out in all spheres of mental health. In this connection, it must be mentioned that in countries where it is customary to care for the mentally sick in their homes, it may be necessary to ensure that only frankly anti-social patients are detained in hospital.

Evidence from countries where "boarding out" and domiciliary care are the rule rather than the exception shows furthermore that these forms of treatment are both workable and effective. Although a wholesale discharge of chronic cases from the mental hospital is out of the question, it is certain that a good number of the patients who live at present in institutions could readily be placed in sheltered employment or cared for by their families with the help of social workers and voluntary organisations. Many cases will, nevertheless, need more or less permanent institutional care. These long-stay patients should certainly not be deprived of the benefits of active medical therapy. WHO statistics show that 10% to 15% of the number respond very well to systematic treatment and, although the improvement obtained will perhaps not be sufficient to make their return to the community possible, it will often make their lives in the institution freer and fuller.

Geriatric patients with mental illness make up a large chronic group occupying a substantial proportion of mental hospital beds. These elderly persons could well be cared for and receive adequate treatment in modified facilities at lower cost. How this can be accomplished is not immediately clear, but it is certain that special arrangements are necessary for them, for the most part outside mental hospitals, and that a community service based on a central clinic as indicated in the blueprint is feasible.

The foregoing is a presentation of the broad principles involved. May I now indicate some of the ways in which this could be implemented.

The community in an integrated psychiatric service is the area from which psychiatrically ill patients come and to which they should return. For purposes of

clarity the community is divided into three areas—home, school and work—but these are closely interrelated.

An integrated psychiatric service needs to be concerned with promotive, preventive, curative and rehabilitative mental health service; and with their integration into most of the existing socio-psychological and health services in the community. Causes of social disorganisation should be sought, and its symptoms (for example, alcoholism, delinquency, divorce, etc.) should be dealt with by multidisciplined groups of persons.

To promote mental health in the "home" area, attention will need to be directed to factors such as:

- Preparation of young people for marriage.
- Study of genetics and heredity.
- Marriage guidance when factors arise which may endanger marriage.
- Training of obstetricians and midwives in the significance of emotional factors in child-bearing.
- Guidance for young parents faced with such problems as the birth of physically or mentally handicapped children; sharing the home with parents; adjustments when marriage partners have different cultural or religious backgrounds.

Effective prevention of mental illness is a community responsibility; it is associated with the control of factors causing social erosion; with a recognition by the community of the need to esablish and expand facilities for improving the social climate and for preventing mental illness.

Trained personnel who have an entry to the homes of the people have unique opportunities for recognising the early signs of socio-psychological breakdown and need to know the facilities in the community available to help. These persons are primarily midwives, public health and district nurses as well as social workers. The need for such workers to work as an integrated team and to know when and where to refer problems to other workers is apparent (for example, a midwife knowing the effects of rejection in an infant and becoming aware of such an attitude may realise that this is a marriage guidance problem and persuade the parents to accept such help).

An enlightened public demands the establishment and expansion of services such as antenatal and postnatal clinics, child guidance and marriage guidance clinics, community and play centres and mental health services. It is recognised that such services will make community living more worth while.

The home and the school areas are intimately interrelated.

Pre-school clinics and nursery schools are areas in which early detection can be made and early treatment of physical or psychological problems can be given in which the family is treated as a whole.

School clinics staffed by doctors, nurses and psychologists need to be available, special schools for retarded children, child guidance clinics for emotionally disturbed children, out-patient clinics and children's hospitals to meet the various physical and psychological needs.

The play and recreational needs of children especially in congested city areas can be met (for example, by closing certain streets to traffic during certain hours).

Square pegs need not be fitted into round holes where vocational guidance and juvenile employment agencies are available.

School and home have, nevertheless, many problems calling for study (for example, deprived children, overindulged children, children from institutions and delinquents).

An enlightened public in which parents, teachers, employees and health personnel work together on problems affecting children is needed. Home, school and work cannot be separated. For example, if both parents work, children may lack necessary supervision. Emotional problems at home affect the child at school and the man at work. The training of children in individual and social responsibility in the home and the school will affect their contribution to work and to society later. The use of facilities such as vocational guidance will help to direct people into the areas of work in which they are likely to be successful.

Well-adjusted people need to work; absenteeism is common in persons with neuroses; enlightened employers of labour are aware that increased production requires an awareness of the needs of workers as persons, not only as technicians. Workers such as personnel managers, industrial nurses and social workers can assist in this aspect, and a close liaison needs to be made with general hospitals, out-patient and psychiatric out-patient services, social welfare agencies and mental hospitals, to enable workers to receive early treatment and to be accepted back on discharge from hospital. Physically or mentally handicapped persons, whether the condition is congenital or the result of injury or disease, may require special training, or retraining, or may need sheltered employment for a temporary or permanent period.

While it is possible for members of a community to agree to promotive and preventive mental health measures, it is equally important for them to recognise that, with the present limitations of knowledge, a proportion of the members of the community will develop mental illness; and this should be accepted and early treatment sought. Some patients will be treated as out-patients, day-patients or night patients and able to continue as members of the community; others will require more intensive treatment in neuroses or other special treatment units; others may need prolonged care and control in mental hospitals or other long-term treatment units. Many cases will recover or improve sufficiently to return to the community. The community may require training and assistance to accept and aid in the rehabilitation of such persons.

Much work remains to be done in connection with this blueprint which, at this stage, is provisional and is presented as a basis for discussion. It is hoped that the plan will be finalised by 1960.

Poems

CLINICAL EVIDENCE

Let us forget now
The diagnosis and the prognosis,
The authorities, and their authorities
Marshalled in the footnotes;
The graphs, the charts . . . the curve of predictability.

We have reasoned deductively,
Tested inductively;
Now let us drop the burden of this—for see!
The pulse leaps to the finger,
The eye brightens,
The patient lives.

—HAZEL KUNO

THE UNCONSCIOUS

Did not the unknown exist
before it was known?
Did not the dark prevail
before it was prone
To arouse the thoughts and
ken of men?

All that we know was before
we knew
And all that is not understood
Still exists for evil or good.
In regions deep
Remain the latent, the buried, the heap,
The residue, the generator from which we power
To prove and disprove,
to laugh and to flower.

—ARTHUR LERNER

THE SCIENCE OF PSYCHOTHERAPY

It is to ravel a thread—one truth—
Out of the multi-dyed, rich-woven fabric of Truth,
And to follow that thread blind-hopefully
Through the psyche's labyrinth turns.

It is to build a tight corral
For taming a few of the soul's wild horses,
Closing one's ears to the herd stampeding outside.

It is whatever can and must be defined
To keep the healer's mind sane, his heart from breaking;
And to allow, sometimes, a slip from science:
Out-thrust of passion . . . compassion
Which pierces and heals his patient.

—HAZEL KUNO

NEUROTIC, DEFENSIVE

Indeed I'm amazed at your virtuosity!
Blindfolded you walk a tight rope,
Swinging your arms for balance.
One false step, you cry,
Would plunge you into a pit of destruction.
While I, unblindfolded, see
You walk just an inch above solid ground.

Terror is terror.
I respect your painful balance.
Yet must I think: How freely you might stride to your goal,
How those swinging arms might embrace life.

—HAZEL KUNO

Book Reviews

PSYCHOLOGY FOR LIVING

By Herbert Sorenson and
Marguerite Malm

New York, McGraw-Hill Book Co., 1957. 672 pp.

This is the second edition of a book for high school students first published in 1948. The chapters have been completely rewritten or revised to incorporate suggestions from teachers who have used the first edition with their classes.

The work is divided into five parts: What personality is and how it is formed; developing and maintaining mental health; physical growth and learning; intelligence and thinking, and two major decisions of adolescents, namely, choosing a marriage partner and choosing an occupation. Each chapter is supplied with preview questions, a summary and review questions or problems. A teacher's manual and a series of objective test questions are also available.

Each chapter is filled with concrete illustrations drawn from everyday activities, numerous photographs and suggestions for correlated films. As an example of concrete material supplied in the discussion, we may cite the chapter on personality. This chapter contains a personality questionnaire, a self-report test and a card from the Rorschach ink-blot test in addition to numerous concrete examples of individual behavior.

When considering this book as a text for high school students, several characteristics assume importance. One is that the discussion seems to be rather disconnected from chapter to chapter. For example, in the early part of the book there is one chapter on habits, how they are formed and modified and the part they play in life. There is also a chapter on basic needs and satisfactions. But when we turn to such a chapter as the one on making a successful marriage, in which one might expect to find a discussion showing how the basic needs are involved in this problem, there is no reference to the discussion in the earlier chapter. The background developed in the earlier part of the book is not used.

Secondly, there is a tendency to oversimplify complex problems. For example, on page 25 the question is raised: When is a personality good? This is answered in seven short lines: "If you are likable," "if you are honest," "if you are a responsible person," etc. There is no suggestion that this is an extremely complex question which man is still in the process of answering.

Similarly in the chapter on getting the most out of studies, the possible influence of seeing a use in what is being studied is mentioned but how "seeing the use" is related to basic purpose or goals is not elaborated. Most of the space is given to such items as schedule, lighting, taking notes, improving the mechanics of reading, learning to concentrate. The concern is with techniques and not with the underlying dynamics.

A third characteristic is closely related to the second. Much use is made of do's and don'ts and rules. The emphasis is on what to do or what not to do rather than on developing a method by which one works out what to do using the underlying dynamics of the person, the situation and the probable effects of alternative ways of behaving.

Thus, although the book is simply written and well illustrated, it would require a very capable teacher who could knit the parts together to help the student develop a method of approaching problems in behavior and development that can be

adapted to the variety of situations which one finds in life. Do's, don'ts, musts, shoulds and rules cannot be substituted for a functional method.—RALPH H. OJEMANN, Iowa Child Welfare Research Station.

THE QUEST FOR IDENTITY

By Allen Wheelis

New York, W. W. Norton & Company, 1958. 250 pp.

The first half of the twentieth century has unfolded an incessant chain of dynamic events ranging from the most fearful and primitive to the most scientific. In turn, these events have challenged old ways of life and the very ego security which spelled out man's identification.

Dr. Wheelis subjects the relevance of psychoanalysis as it concerns the great enigma of our time—a quest for identity—to critical examination. With the decline of the superego and the undermining of many traditional values and adjusting habits, personal unrest and insecurity have become more marked. The individual finds himself searching for a lasting sense of identity. (Is not this what he has always done in one form or another?) The author strikes home the point that man cannot rekindle the identity of the past, for this was not lost but more or less outgrown. Thus, identity is something which must be created and earned. It cannot be sought for merely as a lost mine or landmark.

Psychotherapy can prove to be helpful if it is employed as a method of inquiry subject to amendment as the individual emotional problems change. If, however, it becomes laden with restraints of orthodoxy and dogma, the therapeutic process loses its effectiveness.

The Quest for Identity includes many personal narratives, excellently treated and very readable. They portray the developing social character of the day and offer some measure of social change in the individual. It is refreshing to see a psychoanalyst not only write about social change but also about problems of value and vocational hazards of psychoanalysis.—ARTHUR LERNER, Los Angeles City College.

IF YOU ADOPT A CHILD: A COMPLETE HANDBOOK FOR CHILDLESS COUPLES

By Carl and Helen Doss

New York, Henry Holt & Co., 1957. 368 pp.

Out of their personal experience and with deep understanding of those who want to adopt a child, the Reverend and Mrs. Doss, parents of 12 adopted children of mixed races, write about what is involved in adoption—for the child as well as for the adults. In addition, they have familiarized themselves with professional thinking and literature, which they use as the basis for their advice and suggestions.

The authors attempt to help those who are considering adoption to arrive at an honest answer as to whether they could be good parents for a child, by examining their expectations, their motives, the kind of persons they are, and what a child needs for his well-being and growth. For those who cannot or should not adopt, they present alternatives.

In telling how to go about adopting a child, they correct prevalent misconceptions about the number and kinds of children actually available, and about the practices of social agencies which it is now the mode to attack. They explain the reasons for agency requirements and procedures, and point out the protection and professional casework help offered by agencies.

They consider the legal aspects of adoption and review the laws and procedures in the various states. The improvement of adoption legislation and provision of adequately financed and staffed adoption agency services are seen as the responsibility of community groups.

For those who have already adopted, they discuss how to deal with normal problems of rearing children, as well as those inherent in adoption.

The appendix includes a comprehensive list of adoption agencies by state in the U.S.A. and Canada, with a digest of the laws of each state.

This handbook transmits a conviction that adoption is a means of personal fulfillment for those who have the capacity to experience the true satisfaction of parenthood—contributing to the well-being and development of another person. The authors know that almost any child deprived of his natural parents, regardless of his age or race, needs and can bring gratification to the mature adult who is able to give him love and care for his own sake.—ZITHA R. TURITZ, Child Welfare League of America.

REMEDIAL READING, TEACHING AND TREATMENT

By Maurice D. Woolf and Jeanne A. Woolf

New York, McGraw-Hill Book Co., 1957. 424 pp.

While this book is primarily concerned with the multiple causes of reading disability it also contains the philosophy and theory behind the remedial reading program. Techniques employed in diagnosing, counseling, instructing and evaluating are covered. Case histories and group procedures help make this volume more meaningful from a practical standpoint. This combination of psychological understanding and skill provides remedial reading suggestions for programs covering various age and grade levels.

The reading process itself is at best a very complex phenomenon. When serious authors such as the Woolfs expend time and effort in creating *Remedial Reading*, educators and clinicians, to say nothing of countless youngsters in the classroom, are the beneficiaries.—ARTHUR LERNER, Los Angeles City College.

1957 DIRECTORY OF PSYCHOLOGICAL SERVICES

An approved list prepared by the American Board for Pyschological Services

9827 Clayton Road, St. Louis, Mo., ABPS, 1957. 156 pp.

This is a carefully prepared directory by a special group, all diplomates of the American Board of Examiners in Professional Psychology. It contains a small but selective list of individuals and agencies in the United States and Canada which offer psychological services, both clinical and industrial, to the public. Although only 115 services are mentioned, the directory also lists the diplomates of the American Board of Examiners in Professional Psychology under clinical, industrial, counseling and guidance headings.

The appendices contain a statement from the American Psychological Association on the background and importance of the American Board for Psychological Services, paragraphs explaining the organization and operation of the board, and an outline of the standards in professional psychology.

Agency information and referral services will find this directory useful as a guide when in need of qualified psychologists or

psychological services or the kind of information contained in the appendices. All individuals and services listed have been thoroughly investigated and have met ABPS standards.

Although this initial list does not include all psychological services in the U. S. and Canada, its preparation is to be commended for it is a step in the right direction. This directory has been greatly needed for a long time.—EMILY L. MARTIN, National Association for Mental Health.

THE FAMILY AND MENTAL ILLNESS

By Samuel Southard

Philadelphia, Westminster Press, 1957. 96 pp.

A real depth of understanding and the kind of supportive approach that offers both wisdom and solace are the oustanding qualities of this excellent little book by Dr. Samuel Southard, professor of pastoral care at the Institute of Religion of the Texas Medical Center in Houston.

The volume's potential readership is broad and should include all who come in contact with the mentally ill. Physicians and clergymen, for instance, will find it of great assistance, but the book performs its most valuable service for the families of the mentally ill. The author realizes mental illness seldom affects just an individual; usually the distress and heartbreak it causes reach out to engulf a whole family. This recognition that mental illness is a crisis for all the members of a family is sensitively explored and provides the book's main emphasis.

Realization that one of its members is mentally ill can come with shattering impact upon a family. Frequently there is resentment, and stubborn refusal to accept the facts. The author acknowledges these attitudes and discusses perceptively all of their emotional ramifications.

The problems attendant upon treatment —where to go, whom to turn to, what to do —are considered at length. There is a comprehensive discussion of referral procedures, the commitment process and the family's relationship to the psychiatrist handling the case. If hospitalization is required and the illness is complicated by absence, there may be added problems. In addition to the disruption of family life, the individual roles—such as nominal head of the house, breadwinner and homemaker—may change.

Further emphasis on mental illness as a family problem is brought out in a section that discusses treatment for the family too and where to find the various kinds of professional help that is needed to meet the situation. Encouragement also is given to the family to become involved in the total treatment program of the patient.

A minister himself, Dr. Southard considers the role of religion, as well as psychiatry, in helping both the patient and his family. Knowing this book to be a valuable one—which it assuredly is—Dr. Southard still suggests that no written word can be a complete substitute for personal discussion of these problems with a doctor, a clergyman or a close friend.—VICTOR BALABAN, Ed.D., National Association for Mental Health.

THE PSYCHOLOGIC STUDY OF MAN

By John Money, Ph.D.

Springfield, Ill., Charles C Thomas, 1957. 216 pp.

This book has two aims: to present a "critical inspection of familiar axioms

and theories" in psychology and to make a contribution to theory, particularly in the field of psychotherapy.

The author's psychotherapeutic orientation is evident from the beginning in the sorts of problems presented and in the illustrations chosen. There is much of interest in this approach. Human verbal and non-verbal behavior is seen as "sign" or "signal" of what is transpiring within the person and as reporting upon happenings engendered by some source which may be internal to the person or distant in time. The emphasis upon these signs as information messages is in accord with other recent theorizing.

In approaching his first goal, that of critical inspection of the "axioms" of psychology, the author presents a discussion of the mind-body problem, of the distinction between "reality" and "illusion" and of the problem of heredity and environment. These, of course, are classical problems. This discussion loses much of its force, however, because the author proceeds as if he were unaware of the present state of psychological theory. It has been a long time since a naive dualism flourished in this field or since psychologists innocently assumed that what is "environmental" is eradicable and what is "hereditary" is not. One might also question this statement: "Ever since Freud announced his theoretical decisions about the reality principle as opposed to the pleasure principle, and about the function of the ego to test reality, it has been bad taste to ask philosophical questions about the usage of the concept of reality in psychologic theory."

This book also presents an original theoretical formulation in which ego functioning is analyzed into spectatorship, mastery and control.—JAMES G. MILLER, M.D., University of Michigan.

THE ELDEST CHILD

By Edith G. Neisser

New York, Harper & Brothers, 1957. 174 pp.

The author sets out in this monograph on the problems of the eldest child to place them in the cultural setting of present-day America. To give this setting meaning she first summarizes from a wealth of anthropological material the customs of other cultures, both current and past, as they relate to the treatment of the eldest. They vary from killing the first-born in some primitive cultures to granting them exclusive rights, as in societies where primogeniture is the prevailing custom. Some societies expect the eldest to be a priest; others expect him to be a learned man. Some expect him to assume responsibilities in connection with other members of the family; others expect him to be a sorcerer. This survey of the range of customs and myths in various cultures lays the groundwork for discussing the life of the eldest in our society today.

First consideration is given to the circumstances surrounding the creation of a family by the appearance of the first-born, to what having a child means to the parents in term of their own experiences as children. Following this chapter there is one devoted to the meaning of being the only child in the family, its rewards and its vicissitudes. While being the only one may have its satisfactions in attention, it may also have its difficulties in the many ways in which young parents are unprepared to meet the needs of their first child.

A chapter is devoted to what it means to be the eldest when a second child arrives in the family. Following is a chapter on the eldest in relationship to a number of brothers and sisters, and the many variations that may exist in the sex and age distribution of these siblings, as

well as energy and intelligence factors that may make for serious competition. One chapter is devoted to the subject of the taking of responsibility by the eldest child, a facet of growing up which faces all children but has particular significance for the eldest child. The author discusses the adaption of the eldest to his peer group and also to various special situations.

The material is well written in simple clear English with no professional jargon. Many concrete examples are given of the problems under discussion with many concrete suggestions about the way these might be handled. It is a book that might bring considerable help to young people learning to be parents of their first-born.—JAMES M. CUNNINGHAM, M.D., Child Guidance Center for Dayton and Montgomery County, Ohio.

THE HANGOVER

By Benjamin Karpman, M.D.

Springfield, Ill., Charles C Thomas, 1957. 531 pp.

I have the pleasure to recommend this book wholeheartedly to anyone interested in the problem of alcoholism. Dr. Karpman demonstrates clearly that alcoholism is a symptom of a deeply-rooted psychoneurosis rather than a separate disease entity. His concept of the hangover as largely a psychological state, rather than a purely physical one, is well taken; the hangover is a neurotic reaction intensified by the toxic effects of alcohol. He is correct in postulating that the psychological reaction to a drinking bout is frequently more disabling and disturbing than the physical reaction.

Dr. Karpman formulates that the neuroses of alcoholics do not differ in structure from other neuroses. The strong feeling of guilt that is part of every hangover is stressed; this guilt feeling is largely responsible for the accompanying depression. By studying the hangover one can gain full insight into the emotional life of the individual. In treatment one must treat the underlying neurosis rather than the symptom—the excessive and compulsive drinking.

The book contains 14 case histories. The case histories of the men are most interesting and stimulating and give the reader considerable insight into the psychodynamics of alcoholism. Those of the women, although interesting reading, largely omit the more personal and sexual life which, without doubt, must be closely interwoven with their drinking.

The book is unusually well illustrated, and well written, which adds to its readability. It is a most timely and informative work.—HARRY R. LIPTON, M.D., National Committee on Alcohol Hygiene, Atlanta.

CRIMINOLOGY

By Donald R. Taft

New York, Macmillan Company, 1956. 3rd ed. 779 pp.

In the course of some forty years of psychiatry it has been my lot to review a number of books. I have never been quite happy about it. This reviewing is a very tricky business. Whether you realize it or not, you take upon yourself, ignorant or well-learned as you may be, to pass judgment on the work of a fellow being. It involves delicate value judgments. So who am I after all to review with any degree of competence the work of another man whose field is not as familiar to me as my own field? Generally, is a social scientist competent to review a book on psychiatry? Most psychiatrists will answer in

the negative. Is a psychiatrist competent to review a book on cultural anthropology? Why yes, will say most psychiatrists; but a cultural anthropologist will come back and say positively not, you have to have special training in the subject. It is therefore with some trepidation that this reviewer undertakes to review a book in another field, yet dealing with a subject that is close to his heart.

Sociology has always been a problem to the psychiatrist, especially one who is psychodynamically oriented. The differences between these two disciplines are tremendous and not to be slighted. Criminology is a branch of sociology and at present deals with many social factors that refer to the criminal; psychodynamic criminology, on the other hand, deals with the criminal as a particular individual. Whereas criminology discusses chiefly the effect of the external environment on criminals, psychodynamic criminology refers to factors that have a personal meaning to the individual criminal. Where the psychiatrist emphasizes the individual aspects, the criminologist is concerned with the physical, material and objective aspects. Where conventional criminology discusses things from the standpoint of environment external to the individual, criminal psychodynamics considers everything from the standpoint of the environment internal to the individual. In other words, conventional criminology treats criminals as groups and virtually ignores the criminal as an individual; in psychodynamic criminology, the criminal is the very essence of consideration.

Naturally with two such widely divergent approaches the results must inevitably be different. Criminology, as far as this individual is aware, has never been of help to the criminal. On the other hand, psychodynamic criminology, as far as this individual is aware, forever tries to be of help to the criminal. Psychodynamic criminology within its framework has done everything in its power to help the criminal and has evolved a system of psychotherapeutics that can and has cured the individual criminal. Over and above that, even when the field approach touches on individual aspects, as when the criminologist studies the family, he studies the family only insofar as it contributes to the problem of crime as a whole but does not consider that the presence of the criminal in the family has already changed its viewpoint.

Criminologists posit the question as to whether criminology is a science and ruefully conclude that it has not yet reached that status. Criminology as yet is only an offshoot of sociology and as such pursues the method that has been a part of the general sociological approach. For years it has been influenced by other sciences and has borrowed liberally from the related sciences of biology, anthropology, psychology and so on. So that in a sense sociology has been generally a compilation of material gathered from other sources and put under one heading, with virtually very little material of its own.

It is clear from Dr. Taft's statements that to him a study is scientific only if it can use the experimental method. Along with many others, he carries the fallacious idea that observational investigation is not scientific, that only experimentation can allow one to enter the sanctum sanctorum of science. This, of course, is entirely erroneous. For thus viewed, astronomy could never be regarded as a science; whereas, as a matter of fact, it is one of the best organized scientific disciplines. Paleontology, geology and the many biological sciences such as ichthyology, entomology, ornithology and a host of other disciplines are surely scientific, yet the

nature of the material would positively preclude anything like experimental study, except in a purely secondary supportive way as material for physiology, for example.

While not denying the value of experimental research, one may safely state that its place is limited and that by far the greater mass of scientific data has been gathered through observation. One is not aware that Darwin performed any specific experiments in biology, and his theory of evolution was developed entirely through observation of available material. In medicine most of what is known about neuro-anatomy has been obtained through study of diseased neurological conditions. Where would knowledge of biochemistry be today without the clinician's contributions to diabetes and metabolism, to vitamins and hormones? Observation is merely the study of what one may term nature's own experiments.

All this is only to indicate that the approach of criminology is wrong because it starts with the wrong premise. This is a type of material which by its very nature cannot be studied experimentally; yet it can lend itself to good scientific study if one knows how to use observation carefully and how to correlate the material available. It is not that the material does not lend itself to scientific study, but that the persons who study it are not scientists. Social life does not run in a haphazard fashion, but is subject to definite laws. The determinism that follows Copernicus and Darwin is of the same nature as that of Marx and Freud.

The criminal has been viewed in terms of biology as a mutant or an exception that runs counter to the general gamut of accepted behavior. Anthropologically, criminology has tried to digest Lombroso's ill-fated concept of criminality as an expression of degeneracy, which, although definitely refuted by modern understanding, still finds its place in the various discussions on criminality. On the psychological side, it has tried to measure the intelligence level of various criminals, hoping to find therein some difference that will delimit the criminal from the general population.

All these attempts appear to have failed. The more dynamically oriented students no longer look upon the criminal as a mutant, a degenerate or an intellectual inferior. The one single approach yet left for the criminologist to pursue—namely, the individual dynamic approach—has hardly reached the criminologist, although some feeble attempts in that direction are being made. It has remained for the psychiatrists, more particularly those concerned with mental hygiene and the extramural behavior of children and adolescents, to hit upon the basic core of criminality in studying the various types of behavior deviations.

Of this, unfortunately, we get very little in the book under review. What Dr. Taft gives us is a good all-around, albeit stereotyped study of criminalistics. The textual material does not differ substantially from the material one sees in texts on criminology of the last fifty years. Statistics are there, of course, but one fails to see that any light on criminals has ever been thrown by this or that group of statistics. Does it mean anything that there are more crimes in the winter than in the summer; more murders on moonlit nights than on dark nights; and fewer second-story robberies on rainy days as compared with dry days? A discussion of the relations of crimes to economic conditions, of foreign-born *versus* native Americans, of racial factors, of regional crimes, of religion and crime is presented. Does all this help to understand

the genesis of crime? It does not. One might as well study statistically the number of tall and short men among criminals, or blue-eyed and dark-eyed men, only to come to the remarkable conclusion that the distribution is exactly the same as found in the general population. Rich people steal and poor people steal; educated people murder and ignorant people murder; and the clue to their criminality must be sought not in the economic conditions, nor in intelligence nor in any like factors, but in the roots of their personalities. Criminality is the expression of a life-long reaction, and although a particular crime may have apparently been committed impulsively, it has taken a lifetime to prepare for it.

Thus it is that as one trudges through these endless discussions of social factors, there does not emerge any significant understanding of the problem of criminality, and the chief reason is that criminality is treated as a mass reaction with no attempt to understand the individual problems involved. So one is confronted here, in a sense, with a work written very much like Hamlet without Hamlet in it. There is a lot about murder, but not a word about the individual murderer; a lot about theft and robbery but not a word about the individual thieves and robbers. The central dynamic factor in the entire problem of criminality—namely, the criminal as a person—is completely missing.

Dr. Taft's comments regarding the meaning of psychoanalysis in criminology are nothing to write home about. He quotes Dr. Horney: "Neuroses are the price humanity pays for cultural development." This, he says, is contrary to Freud as neuroses are held due, not merely to suppression of instinctive drives, but to "difficulties caused by the conflicting character of the demands which a culture imposes on its individuals." This strikes us as not understanding Freud at all or understanding him so narrowly that it loses its meaning. One wonders why Dr. Taft found it desirable to quote secondhand from Karen Horney when it is well known that instinct *versus* culture is one of the main tenets of Freud. Dr. Taft could have done just as well by going to original sources some fifteen years previously. Anticipating Horney (?), Freud says: "Civilization is the fruit of renunciation of instinctual satisfaction, and from each newcomer in turn exacts the same renunciation. Throughout the life of the individual there is a constant replacement of the external compulsion by the internal. The influences of civilization cause an ever-increasing transmutation of egoistic trends into altruistic and social ones, and this by an admixture of erotic elements." [1]

It is precisely here that Dr. Taft fails to understand the meaning of repression in the framework of our culture. If he could but understand that repression is not a static process but an ever-acting dynamic process, at work twenty-four hours a day, seven days a week, all the time, he would also realize that repression is rarely successful in the full sense of the word or we would have had a perfect civilization. All neuroses, without exception, may be said to be results of unsuccessful repression. Every now and then we have a break through the iron curtain of repression and then we have an acute neurotic or psychotic episode. Breakdowns are not the only evidences of unsuccessfully working repressions. Criminality, in point of fact, is the result of unsuccessful repression

[1] Sigmund Freud, *Collected Papers.* Vol. 4. London, Hogarth Press, 1948, 297.

which, breaking through the barriers, brings forth criminality in all its pristine form. When a paranoiac goes beserk and kills a group of people, what is it but breaking through of repression? When a man in a state of acute homosexual panic kills many people, what is it but breaking through of repression? When an alcoholic paranoiac having "suddenly" conceived, in a state of pathologic jealousy, that his wife is unfaithful to him, that the children are not his children, kills the entire family and then because of guilt kills himself, what is it but breaking through of repression? It is strange that Dr. Taft, having mentioned the problem of repression, failed to take advantage of this in his attempt to understand human behavior, particularly criminal behavior.

He also says "the neurotic, unlike the psychopath, is overcome by feelings of guilt. These may be extremely painful. On the whole, they seem more likely to drive him in the direction of mental disease than in the direction of crime." Here evidently Dr. Taft repeats a popular misconception that neurotics are not criminally inclined, but if one uses the term neurosis in a broader sense and the ramifications that go with it, it can be observed that neurotics are all too often inclined to crime. Are kleptomaniacs neurotics or psychopaths? Where is the psychiatrist who can draw the line between a kleptomaniac and a common thief? Who knows where murder from passion ends and murder for profit begins? Many psychiatrists that have anything to do with psychodynamics will immediately answer that kleptomaniacs, some pyromaniacs and dozens of other phases of neurosis are definitely criminal and at the same time definitely neurotic.

Eighty-five percent of criminals who were involved in predatory crimes did not, on the surface at least, give any indication of kleptomania but on analysis turned out to be kleptomaniacs of a specific type. What is important on the whole is not the crime one commits but the motives that lead to the crime. If in the commission of a crime a man is motivated by his hostility against authority, he is just as much a neurotic and as much a criminal as any other criminal may be, even as compared to the psychopath.

Dr. Taft calls upon Lindner and on Arieff and Rotman as authorities. The present writer certainly would not call them authorities just because each one wrote several articles on the subject. Dr. Taft mentions none of the works of Maughs or Conn, who have written extensively on the subject. This does not sound like a careful review of the subject of psychotherapy, a subject which has undergone tremendous changes for the last twenty years—changes which Taft has failed to record.

As befits a recently published book—what with the American intelligentsia, both professional and non-professional, having been tremendously influenced by the modern dynamic psychological approach and its emphasis on personal factors and interpersonal relations—this one shows evidence on the part of the author of large acquaintance with the material available. The acquaintance, however, is of the purely armchair variety, and there is no evidence that the author has absorbed and utilized it for the purpose of the study. Freud is mentioned at least once, but no Freudian dynamics are applied; William Alanson White—not William Allen White, blessed be the shades of both these great men!—is mentioned three times, all in footnotes with no attempt to discuss his contributions. Yet he was the father of

criminal psychopathology in America, a pioneer in his own right whose influence still prevails as is evidenced by the contributions of his pupils. The book bristles with all sorts of modern references, but they are all mentioned in passing footnotes and produce nothing, for little of it finds its way into the text.

Criminology as a science is yet to come. It is quite certain, however, that it will never come from the academic criminologists who sit in their offices and from their high chairs think what criminality might be, or who study large numbers and want to extract some significance from the group. It will have to be written someday by a criminologist who is equally well oriented in dynamic psychology and who will follow the study of criminology through the person as Pope advised the study of mankind through man. Such a criminologist will have an intimate appreciation of the dynamics of human behavior with an emphasis on interpersonal relations. It is thus through many such studies of individual criminals that criminology may eventally come into its own.

Within the limits of its framework Dr. Taft has produced a worthwhile and inclusive study of the various social factors involved in criminality, and as such this book may be recommended for classes in sociology and criminology. The criticisms that have been made are essentially concerned with the approach to the subject and would apply equally well to Sutherland and Cressey, Ruth Cavan, Vedder and others. This book compares favorably with the works of these authors. The chapter on the Negro in crime is very sympathetically written. The wider implications of criminology, especially the comparison of crime and war, are discussed very suggestively.—BEN KARPMAN, M.D., Archives of Criminal Psychodynamics, Washington, D. C.

THE ADOLESCENT VIEWS HIMSELF

By Ruth Strang

New York, McGraw-Hill Book Co., 1957. 581 pp.

Dr. Ruth Strang is a well-known educator and always writes with authority and erudition. In *The Adolescent Views Himself* she has covered, in a comprehensive fashion, a truly neglected area of adolescence: "the ways in which adolescents perceive themselves and their world."

This is a practical book directed mainly to teachers and based quite literally on material obtained from thousands of teenagers, supplemented by Dr. Strang's graduate students' observations of adolescents. The author has done an excellent job of describing the many ways in which young people see themselves in "the psychological, social and physical setting in which they are growing up." Dr. Strang does not lose sight of the facts that growth is a continuous process, that the adolescent is an individual, that the "typical" adolescent is a "newspaper stereotype" and a fallacy.

Dr. Strang deals with the many developmental areas of the adolescent. How the young person copes with growing up, with his physical and sexual maturing, with social and peer relations, with the demands of the outside world and the family, with the problem of scholastic or vocational future, with achieving a sense of personal identity and maturity in our society.

In view of the current interest in schools I read with particular interest the sections on scholastic success and failure. It is a chapter helpful to teachers but points up what I consider as diminishing the value of this book. The unconscious factors in motivation, the prime mover in

scholastic success, are only hinted at. And, in general, the unconscious factors in adolescent growth and development are given bare treatment.

Another small criticism is that although the book is very well and clearly written, it is rather heavy reading, as so many texbooks are. Maybe this is inevitable in such a fact-filled study.

This is an eminently practical, descriptive, valuable addition to the literature studying the adolescent. While of special value to teachers, it is of undoubted value to all disciplines working with young people.—JOSEPH R. TEICHER, M.D., Child Guidance Clinic of Los Angeles.

THE LIFE AND WORK OF SIGMUND FREUD

1919–1939, The Last Phase

By Ernest Jones, M.D.

New York, Basic Books, 1957. 537 pp.

This book, the last of a trilogy, is divided into two parts—one a chronological record of events, the other a brief survey of Freud's contribution to various fields of thought. The author was a student and colleague of Freud, who had the advantage of shared experience in many areas and who undertook the work with passionate zeal, but for whom the close association and adulation of Freud inevitably created difficulties of perspective.

The book is a vast storehouse of data and inference. Many interpretations of Freud's reactions and thinking seem unsupported by the facts given and perhaps colored by the author's fantasy. To students of Freud the book is bound to have much interest, painting, as it does, a picture of the development and background of his thinking and of the psychoanalytic movement in Europe. To the lay reader, however, the first part, at least, is bound to be tedious. Eventually (after a laborious effort in reading) a portrait of Freud emerges suggesting a man of great intellectual gift, of sensitivity and directness (best observed in his letters), endowed with exceptional vitality, dedicated to his cause, often provocative, ungracious and demanding, but frequently generous, remarkably perceptive, mellowing as success brought for him a position of unquestioned authority, and enduring the almost unbelievable torment of the last sixteen years of his life with truly heroic stoicism. (Appendix B, a documentation of surgical procedures for his fatal cancer conveys this last as nothing else could.)

Perhaps he was driven to bring order to the apparent chaos of human psychic development and structure, motivation and psychopathology in part at least as an attempt to understand and solve his own neurotic conflicts. However that may be, his need to understand, evident from his earliest years in his searching scrutiny of literature, philosophy, religion, enabled him to pierce the cultural blanket of repression and denial enveloping his late Victorian era, and to discover how man develops and maintains a "self." The great value of this book is its rich source material for future studies of Freud and his work.—NATALIE SHAINESS, M.D., New York City.

THE MODERN BOOK OF MARRIAGE

By Lena Levine, M.D.

New York, Bartholomew House, 1957. 158 pp.

The subtitle of Dr. Levine's book, A Practical Guide to Marital Happiness, seems to describe its contents most accurately.

In the foreword by Dr. Abraham Stone the statement is made that "although many of the viewpoints expressed (in the book) are based on the dynamics of modern analytical psychiatry, the author has refrained from resorting to glib psychoanalytical phraseology." The reviewer certainly would agree with this statement by Dr. Stone that the language of this volume is indeed "simple and straightforward."

As might be expected, since Dr. Levine is a gynecologist, the material in her book is addressed to women and is written primarily for a girl's or woman's point of view regarding many facets of love, marriage, sex and the problems pertaining to these experiences.

This book is divided into seven chapters dealing with many of the problems of marriage as they might relate to a teenager's questions regarding dating, working wives, infertility, promiscuity, etc. and moving along to problems arising in the marriage relationship itself. These problems or questions range from a discussion of how to get along with in-laws to preparing the next generation for their own responsibilities in a marriage.

Dr. Levine writes with sympathy and understanding. Insofar as any written material can help people solve problems within a dynamic relationship, it seems as if her treatment of the subjects of love and marriage can tend to allay individual fears. An attempt is made to discuss in everyday language the possible reality causation of problems in marriage while at the same time the deep-seated personality factors which can tend to create problems within a marriage are not ignored.

Dr. Levine states in her preface: "There was a time when there was a large gap between the findings of experts and their use in helping people. This gap is being narrowed to a greater and greater extent. It is hoped that in a small way this book will serve such a purpose." It is the opinion of this reviewer that this book fulfills the author's expectations.—MARJORIE R. LANDIS, D.S.W., Lehigh Valley Guidance Clinic, Allentown, Pa.

GUIDES FOR SENTENCING

Edited by the Advisory Council of Judges

New York, Carnegie Press, 1957. 99 pp.

Guides for Sentencing is a product of the Advisory Council of Judges established in 1953 as a permanent body by the National Probation and Parole Association. This council is composed of some of America's most distinguished jurists from federal, state and local courts. Their small but highly instructive book marks a point of transition in the development of the operations of probation.

The concept of probation has always had a nominal acceptance in principle by judges, but formerly in practice it did not lessen their task of rendering judgments or their anxieties. It remained for a matter of principle based beyond humanistic incentive alone to reach a level of satisfactory operational practice based upon a disciplined experiment from which predictions of a high order could be obtained. In former times, probation had a larger foundation of sentiment and "hunch"; today it is founded more upon an ordered procedure and controlled method. Today, in jurisdictions which provide adequately for it, the practice of pre-sentence investigation has brought forth a large body of significant guides for judgment. The "hunch" factor remains, and there is yet room for it in every case as an intuitive human element of decision which the experienced judge alone makes. That this point of transition has been reached is confirmed in the statement in the preface by Judge Bolitha J. Laws: "Only judges would have the temerity to

present such a guide to other judges." And the judges who would offer such a guide to other judges are the acknowledged leaders of the American judiciary. This transition in the evolution of probation is also a transition of justice itself in the sense that the practice of probation has brought to justice a means of judging both the offense and the offender within a unitary frame of reference of psychosociological science. Out of this has come an axiom that no one should be imprisoned until it is determined that he is not a fit subject for probation.

Guides for Sentencing contains the essentials clearly delineated in five short chapters: Criminal Justice: Objectives and Setting, Dispositions Available to the Court, The Pre-sentence Investigation and the Disposition, Factors Affecting the Disposition, and Selecting the Disposition. Noteworthy in the chapter on factors affecting the disposition is the reflection of an irresistible trend of thinking which takes into account the personality of the offender, the symbolic meaning of his offense, the transactional nature of the offender-victim interaction that ofttimes triggers the unlawful behavior. Implicit also is the larger acceptance of unconscious motivational factors of criminal behavior, of the repetition principle (neurotic element), the weighing of which guides prediction and corrective management.

The remaining third of the book is occupied by appendices containing descriptions of typical offenders: the alcoholic, the narcotic addict, the mental defective, the psychopathic personality and the sex offender. Suggested reading lists are appended to each description. Two excellent standard samples of pre-sentence investigation reports are supplied, one from the federal probation system and another from an unnamed county probationary agency.

Central to the operation of probation is the pre-sentence investigation. The rationale of the pre-sentence examination is the determination of three questions: (1) Is crime the way of life of the offender? (2) Is the offender changeable? (3) Will probationary measures effect the desired change? The quality of this investigation will spell the weakness or strength of a probationary system, in fact, of the operation of justice itself. California and Michigan require a pre-sentence report on every felon, Colorado in every case of felony in which the court has discretion as to the penalty. Connecticut and Rhode Island require such a report in every case in which the sentence is for a year or more. All cases require pre-sentence reports in New Jersey and in the United States District Courts except for those otherwise directed.

This is an authoritative handbook which comes from judges who need not have ". . . the temerity to present such a guide to other judges"; the temerity may be more appropriately assigned to those judges who disdain the use of such a guide. *Guides for Sentencing* should find a place on the desk of every trial judge upon whom, again in the words of Judge Laws, "The sentencing of the convicted offender demands . . . the best that he has in wisdom, knowledge and insight, as a jurist and a human being."—PHILIP Q. ROCHE, M.D., Conshohocken, Pa.

SOCIAL CLASS AND MENTAL ILLNESS: A COMMUNITY STUDY

By August B. Hollingshead, Ph.D. and Fredrick C. Redlich, M.D.

New York, John Wiley & Sons, 1958. 442 pp.

As our social order becomes more complex, and as the roles that members of our society are called upon to perform become

more intricate, greater reliance must be put on the personality and its integration rather than on the individual as a "hand." Thus, from a functional viewpoint the problem of mental illness is likely to become more "salient" in our society (and in other contemporary large-scale industrial systems) than it was in more bucolic times. Mental illness in society thus resembles the exposed but undeveloped sheet of photographic paper which under the action of the developing bath (increased complexity, specialization and differentiation) acquires sharper and sharper features. And as the rate of complexity continues to mount, mental illness and its impact on society will become more and more strategic, and the problems that medicine and public health address themselves to will become, by contrast, more routine and less critical.

The task of coping with mental illness will require a multi-sided and multi-disciplined approach in which orthodox medicine and psychiatry will have to incorporate into themselves knowledge from several other branches of science. In the nineteenth century the physical sciences helped medicine solve many of its problems; in the twentieth medicine and psychiatry may well have to call on the services of the so-called behavioral sciences, since problems of behavior and personality will become more critical to society.

The book under review, the joint product of an interdisciplinary research team headed by a sociologist and a psychiatrist (the senior authors of the book) is an exciting step in this direction. Two topics which Americans, for a series of historical and cultural reasons, prefer to ignore are examined: mental illness and social class. They surmise that there is some connection between these two phenomena and they hypothesize, more specifically, that:

1. A significant relationship exists between the prevalence of *treated* mental illness and the individual's position in the class structure.

2. Types of diagnosed psychiatric disorders are related to class structure.

3. Treatment depends on the class position of the individual being treated.

4. Social and psychodynamic factors in the development of psychiatric disorders are related to an individual's position in the class structure.

5. Social mobility is closely associated with the development of psychiatric difficulties.

The study was conducted in the New Haven community.

Hypotheses 4 and 5 are to be the subject of a companion volume by Jerome K. Myers and Bertram H. Roberts to be published shortly under the title *Social Class, Family Dynamics and Mental Illness.* From the viewpoint of this reviewer, hypotheses 2 and 3 are the best documented and constitute the real contribution of the volume.

In the nature of the case hypothesis 1 is the most difficult to handle since we have little information on the true prevalence and incidence of mental illness. The striking fact which the authors show, however, is the high prevalence of treated mental illness among the members of the lowest socio-economic group in the population (Class V). In this class the proportion of treated mental patients is more than twice the proportion of Class V persons in the total population. But more important is the fact that the lower the class of the individual, the poorer the treatment he receives (if he receives any). The reason for this is not exclusively an economic one although this factor is important. It is also a cultural one: differences in values and expectations between psychiatric personnel and lower-class patients make it difficult to

establish and maintain a therapeutic relationship. This implies the need for a change in techniques or the need to develop a new type of therapist.

It would be presumptuous to try to detail all the many fascinating and burning issues which the authors raise in their book, and which show how inadequate our handling of psychiatric patients is at the present time. The book is not only a substantive contribution to our knowledge of the relationship between social structure and personality, but it is also illustrative of the kind of cooperative research which may well blaze a trail on the new frontiers of mental illness and mental health. As such, it can be heartily recommended both to social scientists and mental health specialists.—MARK G. FIELD, Ph.D., Joint Commission on Mental Illness and Health.

THE HANDICAPPED AND THEIR REHABILITATION

Edited by Harry A. Pattison, M.D.

Springfield, Ill., Charles C Thomas, 1957. 944 pp.

This wide collection of papers is written by 44 co-authors of acknowledged stature in their fields of work. Each chapter has considerable merit in its own right, including an exposition of the views of the author and affording the reader the opportunity to note the stage of development of the profession or area. If the reader can disregard the varying levels of writing and can skim and leaf liberally, he will find sections of interest and value.

The first part of the book is devoted to "foundations" but the two chapters are hardly broad enough to really fulfill the purposes of the sectional title. The second part of the book is devoted to disability groups. This major section includes some of the best chapters, including one on general principles of psychiatry and psychotherapy by Edward A. Strecker. The third section, another major one, is devoted to professional disciplines and their functions in and contributions to rehabilitation. The last section is a catchall although some of the most important and best-written chapters are found therein. The last two sections show most clearly the great difficulty faced by an editor who tries to bring together so many authoritative writers, namely, unevenness in style, purpose and level. Chapters are written for as diverse an audience as employers, labor leaders, internists, psychologists, psychiatrists, plastic surgeons, librarians, etc.

If this multi-authored book is a true reflection of the rehabilitation field today, one may note interesting characteristics. There are many impassioned pleas for teamwork and repeated exhortations on the economic values of rehabilitation, with personal and social values mentioned secondarily. The writing often has a missionary quality; authors frequently write only about their own facility or program, mentioning few if any shortcomings. If it is true that "Rehabilitation seems to have come of age in the mid-twentieth century . . ." (p.856), then the time is ripe for a mature look at rehabilitation developments with all their strengths and shortcomings.—SALVATORE G. DIMICHAEL, U. S. Office of Vocational Rehabilitation.

METHODS OF GROUP PSYCHOTHERAPY

By Raymond J. Corsini, Ph.D.

New York, McGraw-Hill Book Co., 1957. 251 pp.

Coming at a time when group psychotherapy is enjoying increasing and wide-

spread popularity, this book is of extraordinary value in presenting the history, therapeutic philosophies, scientific rationales, modes of application and methods of evaluation that have highlighted the rapid developmental course of this significant form of treatment.

As a scholarly and comprehensive summing up of the many important contributions that have been made to this remarkably complex field of interest, Dr. Corsini's pithy yet concise presentation is without an equal in the literature. The author's rich and varied background shows through in his able integration of abstracted material from over 400 reference items as well as in his sensitive selection of clinical examples.

The obviously great amount of effort invested in bringing together factual information from many sources, including some not readily available, will save every group therapy dilettante, neophyte, therapist, instructor, supervisor, consultant and dean much time in becoming acquainted with the truly vast scope of this promising system of care and field of study.

The chapters on history, comparison of theories, psychological mechanisms and methods and application of group psychotherapy make the book particularly valuable as a primer.

The author has clearly attempted to present an impartial and fair panorama of group psychotherapies. However, some bias is evident in subtle value judgments and omissions that punctuate the contents. This is especially evident in the book's treatment of psychoanalytic theory and therapy, which have contributed too much to the understanding and dealing with man's nature to merit the cursory discussions found in the book, as well as the equal-space implication that analytic theory is comparable to any piecemeal hypothesis or postulate.

On this latter score discriminating readers will be disappointed by some of the passages which show lack of profundity and deserve greater elucidation. Examples of shallow references to sensitive areas of therapy and theory are the following: ". . . in any truly interactive group, the members progress roughly at the same rate." "There seems to be no question that what we call neurosis is essentially a breakdown of communication." "It is of interest that many modern students of psychoanalysis have abandoned the concept of the importance of instincts."

Were the author better versed in all the schools of thought he strives to outline, he would know the answer to his own question, "There is, however, one puzzling aspect about intellectualization. The patient often appears to have learned what he knew all along. Such statements as 'I always knew it, but I never really understood. . . .' or 'I have been told this many times, but somehow I never could believe . . . .' illustrate the paradox of learning in psychotherapy."

The author's entire concept of psychotherapy becomes particularly vulnerable when evaluated in the light of the following passage: "Furthermore, it is clear that the religious and therapeutic *means* (italics are reviewer's) whereby the good life is to be attained are essentially the same." This statement constitutes a serious confusion of goals and processes.

One of the disadvantages of attempted impartiality by an authority in a given field is the tendency to dilute anchorage concepts in a mass of controversy. This becomes evident when the author strives to answer the question: "Is group psycho-

therapy individual therapy, or is it something else?" In the many references to this question the important fact becomes obscured that group psychotherapy is a situation in which the *individual* obtains therapeutic benefits in a group setting.

Despite the misinterpretations and errors, some of which have been mentioned, this is an important book. It is an outline and guide to serve as a good beginning for those who will augment their knowledge and proficiency through further reading and training.—MAURICE E. LINDEN, M.D., Philadelphia Department of Public Health.

Notes and Comments

By mid-February, 40 national organizations with a total membership of close to 50,000,000 had expressed their enthusiasm for Operation Friendship and their intention of participating actively in this NAMH project. Its aim is to bring 750,000 visitors —as many visitors as patients—to the nation's mental hospitals during Mental Health Week, April 26 to May 2.

During this nation-wide, week-long "open house" three-quarters of a million citizens will get a first-hand view of mental illness and the mentally ill. NAMH believes the experience will go far to reduce the stigma which has for so long handicapped mental patients in their struggle back to health.

The national kick-off program will be held April 26 in Washington, D. C., where patients and high government officials will take part in an impressive ceremony at St. Elizabeths Hospital. As they ring the Mental Health Bell, cast from chains and shackles that once bound mental patients, they will touch off similar ceremonies in hundreds of other hospitals across the nation. Working with the NAMH public relations department, Chaplain Ernest E. Bruder of St. Elizabeths is coordinating details of the national kick-off program.

Wholeheartedly endorsing Operation Friendship, Dr. Winfred Overholser, the eminent superintendent of St. Elizabeths, wrote NAMH: "We look forward to joint participation in what we trust will prove to be a major venture in dealing with mental illness and its attendant concerns."

Another important endorsement comes from Dr. J. F. Casey, chief of neurology and psychiatry for the Veterans Administration. Of Operation Friendship he writes: "I think the idea of Operation Friendship is a very excellent one. We in the Veterans Administration have always cooperated to the fullest extent in Mental Health Week and will do so this year. We will send out information to our various hospitals urging them to participate fully."

Operation Friendship is also expected to bring about closer ties between mental hospitals and the communities they are in or near. After seeing for themselves, visitors to the hospitals will have a much better understanding of the patients as sick people needing treatment, the project's backers believe.

The entire operation will carry out the Mental Health Week slogan: "With *Your* Help, the Mentally Ill Can Come Back."

The large national organizations which have already agreed to participate are the American Home Economics Association, American Nurses' Association, American Psychiatric Association, American Psychological Association, American Social Hygiene Association, Association for Family Living, Association of the Junior Leagues of America, B'nai B'rith, Boy Scouts of America, Camp Fire Girls, Central Conference of American Rabbis, Church of the Brethren, Civitan International, Council of Liberal Churches, Dale Carnegie Alumni Association and Fraternal Order of Eagles.

Others are the 4-H Clubs, General Federation of Women's Clubs, Ladies' Auxiliary of the International Association of Machinists, Lions International, Loyal Order of Moose, National Association of Social Workers, National Council of Catholic Men, National Council of Catholic Women, National Council of the YMCA's of the USA, National Council on Alcoholism, National Education Association, National Federation of Business and Professional Women's Clubs, National Grange, National Jewish Welfare Board, National League for Nursing, National Probation and Parole

Association, National Recreation Association, Optimist International, Salvation Army, Sertoma International, Unico National, United Community Fund and Councils of America, Veterans Administration and Zonta International.

These organizations are urging their state and local chapters to participate actively in Operation Friendship and to cooperate with mental health associations in publicizing the project and in arranging for their members to visit the hospitals. They are pointing out: "Your visit will enable you to observe what goes on in a mental hospital, to meet the hospital staff, to learn about the new and hopeful developments in the treatment of mental illness, to participate in interesting programs."

Besides eliciting formal endorsements from major mental health authorities and enthusiastic responses from major membership organizations, the "visit your mental hospital" idea has enormous appeal for the civic-minded of all ages. Take the Girl Scouts, for example.

Jumping the gun on Operation Friendship, the girls of Troop 206 in Osawatomie, Kans., have already visited the state hospital located there. Wearing their trim green and white uniforms, 23 girls and their leaders entertained patients on several wards. They recited the Scout's oath, sang some songs and visited with the patients, who pelted them with questions about their uniform and badges.

The girls explained that one of the requirements in attaining First Class Scout rating is to "plan a new adventure in friendship that you and your troop can carry out as a way of showing your thoughtful understanding of people in the community."

Setting an example for a whole nation to follow, the girls of Troop 206 voted to make their new friends among the mental patients of Osawatomie State Hospital.

TRAINING

Four regional training institutes on mental health education in business and industry will be conducted by NAMH this spring and fall. They are to be held—probably in Hartford, Milwaukee, New Orleans and San Diego—for the staff members and professionally trained volunteers who are responsible for expanding the educational services provided by state and local mental health associations.

Each 3- or 4-day course will be led by Dr. Harry Levinson, director of industrial mental health for the Menninger Foundation. Each will focus on the content and techniques that have proved most useful in the organization of mental health programs in business offices and factories.

Among the topics that will be covered are the psychodynamics of behavior, personality problems in communication, personality factors in leadership, and problems of executives.

At the first session, participants will discuss the various educational services that mental health associations should provide for industrial workers. As a special feature of the 2nd and 3rd sessions, Dr. Levinson will demonstrate exactly how to conduct a 2-day workshop for a small group of local industrial executives. In each community he will have the help of local psychiatrists and psychologists. At the final session, the mental health association representatives will analyze the techniques used by Dr. Levinson in the demonstration. They will also work out various problems typical of those that arise in the development of industrial mental health programs.

On returning home, participants will schedule similar 1- or 2-day workshops for local business and industrial leaders. As a further service, they will also arrange for small groups of executives to meet regularly to go over the mental health problems that

arise on the job. These unique clinical group education sessions, in which selected local business leaders regularly analyze human relations problems in their own organizations, are foreseen as the primary dividend from the four institutes.

As another aid to mental health associations, NAMH will publish a manual based on Dr. Levinson's lectures and demonstration. It will serve as a ready-reference guide in organizing and expanding this mental health service to the community.

* * *

Grants to further the training of four Protestant ministers and three Roman Catholic priests who will pursue careers as chaplains in mental hospitals or train others in mental-health chaplaincy have been awarded by the Academy of Religion and Mental Health, New York.

The awards, totaling $4,050, were made under the chaplaincy fellowship program of the Smith, Kline & French Foundation, Philadelphia. The academy made three similar grants last year under the same program.

* * *

The 17th annual session of the Yale University summer school of alcohol studies will be held from June 28 to July 23. There will be lectures, seminars and workshops for a maximum of 275 students. Further information is available from the Registrar, Yale Summer School of Alcohol Studies, 52 Hillhouse Ave., Yale Station, New Haven, Conn.

* * *

Sixteen more grants for in-service training of workers in mental institutions of southern states have been awarded by the Southern Regional Education Board.

The grants went to staff members of mental institutions in Kentucky, Louisiana, North Carolina, South Carolina, Virginia and West Virginia. A total of 47 grants have now been made by SREB under this program.

The SREB grants, made possible by a $90,000 subsidy from the National Institute of Mental Health, are designed to enable staff members of southern mental hospitals or training schools to observe new or unusual programs in hospitals anywhere in the country to help them improve their own programs.

Grants are available to administrative, professional and operational personnel such as ward attendants, aides, nurses, rehabilitation personnel, clinical directors, superintendents and others.

Applications for the grants are still being accepted by SREB. There is no deadline, and applications are acted upon as they are received. Applicants should write directly to the Southern Regional Education Board, 881 Peachtree St., NE, Atlanta 9, Ga.

CARE AND TREATMENT

In his inaugural address to the Connecticut legislature Gov. Abraham Ribicoff called for:

- The establishment of a mental health center in New Haven in connection with the Yale University Medical School.
- The establishment of community hospitals as branches of the state's mental hospital program.
- Replacement of an antiquated building at the Connecticut State Hospital with a community psychiatric hospital of 250–300 beds.
- The creation of facilities for more chil-

dren at the Connecticut Child Study and Treatment Home.

• The expansion of community psychiatric clinics.

* * *

Last year, as one of the final phases in a detailed appraisal of New Jersey's mental hospital program, seven of the state's hospital superintendents studied the administration of Britain's famed open hospitals. Returning from their tour they formulated a set of principles based both on their self-examination and on their observations in Britain.

Their statement of principles—designed to lift the therapeutic level of all New Jersey's mental hospitals—was presented to each institution's managers and to the Board of Control of the State Department of Institutions and Agencies. At its February 19 meeting the board approved the principles as reflecting the official policy of the state government.

The full statement follows:

WHEREAS it is generally accepted that psychiatric disabilities are illnesses in the medical sense of the term, and that the symptomatology shown by a majority of psychiatrically ill patients is not of an aggressive, anti-social or purposefully self-destructive nature; and

WHEREAS it is believed that patients suffering from such disorders respond best to treatment given with considerate understanding of the feelings and sentiments of those so afflicted, in an environment which does not of itself alarm the fearful or challenge the uncooperative; and

WHEREAS the reports of the Medical Directors have pointed to the medical effectiveness of programs in the United States and in Great Britain which give full recognition to these principles: Therefore be it RESOLVED, that the State Board of Control affirms as its policy the encouragement in these institutions of programs for the improvement of the physical surroundings in which patients live, and the continued development of practices which insure for all patients the greatest amount of self-determination and personal liberty compatible with their clinical state.

In furtherance of this policy the Director of Mental Health and Hospitals will consult with the Medical Directors of the several hospitals concerned, with a view to the expeditious removal of clinically inappropriate restrictions and the development of physical surroundings more conducive to the patients' mental health.

It is anticipated that the Director of Mental Health and Hospitals and the several Medical Directors will:

1. Study the effects of a materially higher percentage of voluntary admissions on the patient, the hospital and the community.

2. Re-examine our regulations and attitudes toward the easy readmission of patients to hospital.

3. Scrutinize the pre-admission services offered decompensating individuals with a view to facilitating hospitalization when it is necessary and acquainting them with alternative community services when it is not.

4. Assess the nature and extent of the responsibilities given our nursing personnel in order to capitalize as fully as possible on their unrealized potential.

5. Examine our traditional insistence that eradication of pathology is the only proper medical goal and to determine whether an equally important end may not be the social rehabilitation of the patient.

6. Explore the possibility of day care

programs for those aged individuals who would otherwise require hospitalization.

7. Determine the extent to which living arrangements for our patients can be improved through assurance of an increased measure of privacy, interior decoration of buildings, reduction in the size of nursing units, rearrangement of beds, development of recreational space and playing fields, replacement of unsatisfactory furniture, and individualization of patients' dress.

8. Work for the reduction in the bed capacities of all our hospitals and to insist on the construction of new institutions if the alternative is the erection of bed containing buildings at existing installations.

9. Examine our whole system of clinical records with a view to retaining whatever is essential and eliminating all that serves no clear purpose.

10. Investigate alternative methods of budgeting which offer promise of simplifying the fiscal administration of our hospitals.

• • •

Dr. Bertram Mandelbrote, a leading English spokesman for the open (unlocked) mental hospital, will arrive in this country early in April for his third series of conferences with U. S. mental hospital officials. This trip, like the two which preceded it, was organized by NAMH and affiliated state mental health associations.

Immediately on arrival Dr. Mandelbrote will take part in the mental health telethon to be held April 4–5 in New York City. His tentative itinerary then includes Jacksonville, Fort Lauderdale and Miami, Fla.; Columbia, S. C.; Austin and Galveston, Texas; Des Moines; Galesburg, Ill.; Minneapolis; Philadelphia and Reading, Pa.

In each of these cities he will pass on to the heads of mental hospitals and mental health associations the benefit of his experience as the administrator of two open hospitals in Gloucester. Good hospital-community relations and an informed, interested public are essential to the success in the opening of mental hospitals, Dr. Mandelbrote has found.

He has now carried the open hospital idea to almost a third of the U. S. On his first trip, late in 1957, he visited 11 public and private mental hospitals in New York and New Jersey. On the second, last year, he talked with hospital administrators in Connecticut, Massachusetts, Maryland, Indiana, Illinois, Michigan, Ohio, Missouri, Louisiana and Washington, D. C.

In Reading, Dr. Mandelbrote will also discuss fundamental changes in the laws of the United Kingdom regarding the mentally ill, now pending before Parliament. The changes proposed are designed to give the maximum encouragement to patients suffering from any form of mental illness or disability to seek treatment promptly and voluntarily but at the same time to insure that there are adequate restraints and safeguards for patients who, in their own interests or for the safety of others, must be compulsorily admitted to the hospital and detained during treatment.

The bill provides for:

- A single legal code to cover both mental illness and mental deficiency.
- Care for any type of mental patient in any type of hospital rather than in designated hospitals.
- The establishment of a mental health review tribunal for each of the 15 hospital regions in England and Wales, with power to discharge patients.

Other topics covered in the proposed law are categories of patients, special provisions for psychopathic and subnormal patients, detention safeguards, powers of discharge,

powers of the courts, and protection of the public.

If and when the bill becomes law, MENTAL HYGIENE will excerpt those elements of special interest to U. S. readers. Meanwhile, copies of the bill and a discussion of it are available on short-term loan from Dr. George S. Stevenson, editor. They can also be obtained from the British Information Services, 45 Rockefeller Plaza, New York 20, for $1.25 postpaid for the bill and 23¢ postpaid for the parliamentary debate.

* * *

Haiti recently dedicated a new psychiatric institute, built with funds supplied by three U. S. drug companies. It is headed by Dr. Louis Mers, for many years Haiti's only psychiatrist and the founder of the National Mental Hygiene League.

* * *

Extensive psychiatric procedures are now covered by the New York State workmen's compensation fee schedule. A new schedule which went into effect March 1 calls for higher fees and increases payments for rehabilitation procedures.

Psychiatrists are now allowed $25 for the initial interview, up to $200 for shock therapy and up to $225 for psychotherapy in the doctor's office or in a hospital. Under the old schedule they were paid only for the initial psychiatric interview, with the fee set at $15.

Rehabilitation specialists will now be paid for such services as psychosocial determination, vocational guidance, daily activities testing and physical and occupational therapy. Under the old schedule they were allowed only $25 for examination, observation and consultation.

* * *

More mental health services are America's top priority community need, a nationwide panel of federal, state and local public health directors said recently.

The officials were polled by the American Public Health Association in the first of a series of surveys aimed at keeping track of shifting public health trends.

* * *

Conversion of employees' quarters at Pennsylvania's state mental hospitals to the use of patients has added 2,055 beds.

It would have cost the state $12,330,000 to provide similar new facilities, according to Public Welfare Secretary Harry Shapiro. Remodeling cost $182,640.

Eighteen of the 21 institutions have remodeled buildings formerly occupied by employees to provide 14 rehabilitation centers, 31 therapy areas and 87 offices, conference rooms, lounges and nursing stations.

* * *

On every hand these days is telling evidence that mental patients are breaking through the barriers that long isolated them from the rest of the community.

For example, five years ago not one general hospital in Kansas would take mental patients. Now 68 of the state's 167 licensed hospitals will accept them, for temporary care at least.

* * *

The third intensive treatment unit for newly admitted geriatric patients opened last year at Hudson River State Hospital, Poughkeepsie. It was organized by the New York State Department of Mental Hygiene.

The unit is treating patients over 65 with psychiatric conditions who stand to benefit from intensive therapy. Its aim is to rehabilitate as many as possible so that they can return to their families or be

cared for in foster homes supervised by the hospital's social service department.

The intensive treatment program includes medical and nursing care, physiotherapy, occupational therapy, psychotherapy and tranquilizing drugs. Social work counseling is also provided.

Similar units were set up in 1956 at Central Islip and Buffalo State Hospitals.

* * *

Volunteers are providing each new patient at Willmar (Minn.) State Hospital with a "welcome packet"—an expansion envelope containing a pencil, stationery, postage stamps, a calendar and an address book. The envelope, a handy place for the patient to store letters from his family and friends, bears his name and the following message: "This correspondence folder is a gift from the volunteers of the community, who wish you a short stay at the hospital."

* * *

Adequate care of Pennsylvania's mental patients and retarded children will cost at least $185,000,000 or $190,000,000 during the next two years, according to figures complied by Pennsylvania Mental Health, Inc., NAMH affiliate.

The 17 state hospitals with their 39,000 patients will need most of this—$150,000,000. Increased facilities for mentally retarded children—there are 2,500 on the waiting lists of the four overcrowded state schools—and improvements will take another $32,500,000.

The Eastern Pennsylvania Psychiatric Institute, the state's major research and training installations, will need $6,000,000 during the next two years, study shows. Another $8,000,000 ought to go into state aid for 32 community clinics, psychiatric beds in general hospitals, mental health centers, and foster home, boarding home and special after-care programs.

PMH figures a minimum of $3,000,000 will be required for residential care and treatment of the state's mentally ill children. Well-distributed diagnostic centers are needed, as well as small expertly-manned treatment centers.

Sound leadership of the state program will cost $3,000,000, Pennsylvania Mental Health estimates. This allows for competent administrative aides to the State Commission of Mental Health, for specialists in the various mental health disciplines, and for the training of additional psychiatrists, psychologists, psychiatric social workers and nurses.

By July 1, 1961 Pennsylvania will be spending at the biennial rate of $202,500,000 if it is to provide adequate care for the mentally ill and retarded, the NAMH affiliate foresees.

* * *

A 5-year program to improve mental health facilities in Louisiana is getting underway under the joint auspices of the Louisiana Association for Mental Health and the State Department of Hospitals.

Dr. Loyd Rowland, executive director of the association, said the first objective was to obtain an adequate appropriation for the state's mental hospitals.

"Louisiana has been next to the lowest among the states in spending money for mental hospitals," he said. "If we are going to reduce the size of our mental hospitals, we must first spend money to get better services for them. We shall get what we pay for, and no more."

Other recommendations call for more open wards, larger staffs and smaller hospitals, family care programs, use of nursing homes and volunteer help programs, case

reviews for hospitalized patients, mental health treatment centers for outpatients, larger staffs for guidance clinics, psychiatric wards in all public hospitals, and increased mental health education.

Jesse Bankston, director of the hospital department, said:

"This program represents goals which we feel are within our reach. Our objectives are reasonable, and with hard work and cooperation of the public and our state and local officials, we can expect to achieve them."

REHABILITATION

Five patients were discharged recently after spending a total of 183 years in Kentucky's Western State Hospital.

Four went to a nursing home and the fifth to a job obtained with the help of the hospital. The oldest, a man of 81, had been at the hospital 51 years. Three others were 77, in the hospital 54 years; 74, hospitalized 48 years; and 80, admitted at 60.

Last year almost 50 patients 65 or over have left this hospital for nursing homes.

* * *

Fifty-one patients of Greystone Park (N. J.) State Hospital are studying public speaking. The 10-week course is conducted by the Morristown Speakers Club and professional men from Dale Carnegie, Inc.

LEGISLATION

Dr. Paul V. Lemkau of Baltimore is the first chairman of the new legislative committee of the National Association for Mental Health. Dr. Lemkau, a psychiatrist, is professor of public health administration at Johns Hopkins University and a former director of New York City's Community Mental Health Board.

Other members of the committee are James S. Adams and Dr. William Malamud, New York City; David C. Crockett, Boston, and Paul Johnston, Birmingham. Mrs. Virginia Beecher-Smith is serving as the staff coordinator.

The committee's purpose is to provide information and guidance on federal and state legislative matters to mental health associations, and through citizen action to achieve the basic NAMH objective of working toward "the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health."

The committee's primary function is to recommend to the NAMH board the establishment of policies affecting the legislative program. In doing this, the committee will:

- Obtain, evaluate, recommend and disseminate information on federal legislation, including budgets, related to the mental health field.
- Recommend an official position on national mental health legislation and budgetary matters.
- Implement this position by appearing before legislative bodies and other groups, and in other ways.
- Disseminate information to state and local mental health associations concerning this official position, to the end that coordinated support be obtained.
- Furnish state mental health associations with available information on existing state legislation.

The committee has announced that policy decisions on state and local legis-

lative matters will remain the exclusive prerogative of state and local mental health associations. The committee will serve in a consultative capacity and only when invited to do so.

For the present, at least, the committee expects to concern itself primarily with legislative matters of the National Institute of Mental Health of the U. S. Department of Health, Education and Welfare. It is likely also, Dr. Lemkau said, that the committee will propose the adoption by all states of the Interstate Compact, a reciprocal agreement now in force among 11 of the 49 states which provides for hospitalization of non-resident mental patients.

As a long-term project, the committee expects to draft a legislative guide for state and local mental health associations.

The committee has accepted, in principle, a resolution calling on Congress to increase the amount of federal funds available to the states as grants-in-aid for community mental health services. For a number of years the appropriation for this purpose has been set at $4,000,000. The resolution was submitted by the Alabama Association for Mental Health.

RESEARCH

A 10-year study of the adjustment made by discharged mental patients is getting under way at Moose Lake State Hospital near Duluth and in St. Louis County, Minn. It is being conducted by the National Institute of Mental Health in cooperation with the Minnesota Department of Public Welfare.

The long-range investigation is expected to provide guidelines for effective use of follow-up services and community resources in the rehabilitation of discharged patients throughout the nation. Relationships among the hospital, the patients and the community will be studied, according to Dr. Joseph C. Lagey, director of the project. A major objective will be to determine what kinds of services are most useful to the 12,000 patients expected to be discharged from Moose Lake State Hospital during the next 10 years.

A staff composed of 15 psychologists, sociologists, social workers and clerks is working on the project in close cooperation with Dr. Henry Hutchinson, superintendent of the hospital, and his staff.

* * *

The mental health of patients and personnel in general hospitals is to be the subject of an international study under the auspices of the International Council of Nurses, International Hospital Federation and World Federation for Mental Health. Member associations of these world bodies in 12 countries including the U. S., have been asked to participate.

It is hoped that the study report will be a significant feature of World Mental Health Year. The investigation is being financed by the Grant Foundation, New York City.

* * *

The first applications for grants under the expanding research program of the National Association for Mental Health will be acted on this month by a committee of 12 nationally-known medical scientists and health authorities.

The program is headed by Dr. William Malamud, NAMH research director and former chairman of the division of psychiatry at Boston University. Members of the committee include:

Dr. Harold W. Elley, retired director of research for E. I. duPont de Nemours & Co., chairman.

Dr. Philip Bard, dean of the medical faculty at Johns Hopkins University and

director of the department of physiology.

Dr. Francis J. Braceland, psychiatrist-in-chief of the Institute of Living, Hartford, Conn.

Reginald G. Coombe, 1st vice-chairman of the NAMH board.

Dr. John C. Eberhart, executive associate of the Commonwealth Fund.

Dr. George E. Gardner, psychiatrist-in-chief, Children's Hospital, Boston; professor of psychiatry, Boston University Medical School; member of the mental health study section of the National Institutes of Health.

Dr. Ernest M. Gruenberg, member of the technical staff, Milbank Memorial Fund; clinical professor, Columbia University; former executive director of the New York State Mental Health Commission.

Dr. Seymour S. Kety, associate director in charge of research, National Institute of Mental Health; professor of clinical physiology, University of Pennsylvania School of Medicine; former medical director of the U. S. Public Health Service.

Dr. Morton Kramer, chief of the biometric branch of the National Institute of Mental Health; former statistician for the New York State Department of Health.

Hugh G. Payne, executive officer, Oklahoma Medical Research Foundation.

Dr. Heinrich Waelsch, chief biochemist, New York State Psychiatric Institute.

Dr. Stewart Wolf, chairman, department of medicine, University of Oklahoma Medical School.

A $100,000 contribution to the program by the Rockefeller Brothers Fund was announced last December. The gift, to be applied over the next four years, is in addition to the fund's annual contributions to the association.

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French researchers, studying weight increments of infants from 3 to 18 months of age in a residential nursery, found that more than 100 of the infants gained weight regularly in the last weeks of each calendar month but did not gain during the first 10 days of each month. This periodic arrest of weight gains was attributed to the complete turnover of student baby-nursing personnel on the first day of each month. In a comparable nursery where personnel were not rotated, most infants gained regularly in the first half of the month.

The study is reported by Paul Bertoye and C. duMorand of the Pouponniere de la Croix-Rouge in Lyon in an article, "Troubles de croissance du nourrisson par choc affectif," (Disturbance of the Growth of Infants Caused by Emotional Upset), *Revue d'Hygiene et de Medicine Sociale* (Paris), 5(1957), 187–89, and abstracted by W. M. Schmidt in *Child Development Abstracts and Bibliography*, 32 (3 and 4, 1958), 81.

PUBLIC INFORMATION

Radio station KGDE in Fergus Falls, Minn., is promoting closer hospital-community relations by regularly including in its round-up of local news a report of events at the state hospital located there. The stories, which cover daily activities, give the public a good idea of what goes on at the hospital and what is done for the patients.

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The Advertising Council has voted to continue its nation-wide Better Mental Health campaign for another two years at least.

Working as a team with the National Association for Mental Health, the council has already distributed thousands of advertisements for use by television and radio stations, outdoor advertisers, newspapers, magazines and transit companies. Each ad

stresses the need for better understanding of the 17,000,000 Americans who are to some degree afflicted with mental illness.

Sullivan, Stauffer, Colwell and Bayles, a New York advertising agency, volunteered to create ads for the campaign.

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Mental illness and mental health in the world today will be the theme of World Health Day, to be observed April 7.

MEETINGS

Shifts in treatment of the mentally ill have created a great demand for more social workers, the Council on Social Work Education was reminded at a meeting in January. Greater appreciation by social workers of the role played by mental health volunteers is also essential, it was said.

Mrs. Ruth I. Knee, psychiatric social work consultant for the National Institute of Mental Health, said the removal of bars and locked doors from mental hospitals symbolizes the changing attitude in patient care. The community and family are closer to the patient, he participates more fully in democratic life in the hospital and his separation from the community is not so long, she pointed out.

The growth of psychiatric units in general hospitals—there are now 1,000 compared to less than 50 ten years ago—was also said to help fill the gap between the patient and his family.

These changes require more work with the patient in his home and community, family counseling and assistance, Mrs. Knee said.

Miss Mary Mackin, NAMH director of volunteers, called on social work educators to develop a greater understanding of the unique contributions of mental health volunteers. She pointed out that social work schools should broaden their curricula to include courses on staff-volunteer relationships and on the training, supervision and recognition of volunteers.

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The 3rd Latin American Congress on Mental Health was held October 27 to November 15, 1958 in Lima, Peru, under the auspices of the Peruvian government. All Latin American countries participated, plus Haiti, Puerto Rico and French Canada.

The main topic—the present state of Latin America's mental health—was considered from 6 angles: mental illness in urban and rural areas; migration and intercultural conflicts; alcoholism and dope addiction; industrial mental health; community organization for mental health, and social problems such as delinquency and prostitution.

There was special stress on community organization, with discussions centering on the influence of the community and of housing on mental health; cultural and educational influences on youth; family organization and mental health; and surveys and the evaluation of plans for mental health services.

The Latin American countries were advised to intensify their studies of the extent of mental illness in both rural and urban areas as the basis for effective, coordinated community mental health planning. They were also urged to establish psychiatric services in general hospitals, to create mobile services to handle psychiatric problems in rural areas, and to provide more psychiatric training for general practitioners.

Participants took note of the value of transcultural studies in Mexico, Peru and Cuba. They also considered the possibility

of integrating into the immigration services of each country psychiatrists and other technicians equipped to foresee and handle problems arising out of migration.

Campaigns against the use of alcohol and toxic drugs should be intensified, the participants decided, agreeing to sponsor a seminar this year in Santiago on alcoholism in Latin America. It was also suggested that the best way of combatting drug addiction in the Latin American countries is to raise the standard of living among those who use drugs as a substitute for food. The public health ministers of the affected countries were urged to confer on this problem.

Pointing to the rapid increase of industrialization in the area, the congress recommended the establishment of human relations institutes and centers for the study of industrial psychology.

Other speakers noted the need for coordinating housing and mental health planning; for improving children's literature and movies, as significant influences on mental health; for studying the economic and social causes of delinquency; for modernizing the child welfare laws; and for providing penal and correctional institutions with the services of psychiatric teams.

The Latin American Association for Mental Health, meeting in Lima in conjunction with the congress, elected the following officers: Dr. Carlos Nassar, Chile, president; Dr. A. C. Pacheco e Silva, Brazil, vice-president; Dr. Baltazar Caravedo, Peru, general secretary; Dr. Alberto Mateo Alonso, Venezuela, treasurer; Drs. Mario Sbardi of Argentina, Jose A. Bustamante of Cuba, Ricardo Ponce of Guatemala and Jose M. Alvarado of Bolivia, directors; Drs. Guillermo Correal Sanin of Colombia and Ricardo Rodriguez Pane of Paraguay, substitute directors.

Both the congress and the Latin American association plan to participate in the observance of World Mental Health Year.

The 4th congress will be held in Santiago in 1960, the 5th in Caracas in 1962.

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Mental health workers from scores of countries will gather in Barcelona August 30 to September 5 for the 12th annual meeting of the World Federation for Mental Health. The Liga Española de Higiene Mental will be host. "Planning for Mental Health" will be the theme of all sessions.

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The 7th annual Karen Horney Lecture, sponsored by the Association for the Advancement of Psychoanalysis, was given March 25 in New York City by Dr. Leo Kanner. His topic was "Centripetal Forces in Personality Development." Dr. Bella S. Van Bark is chairman of the lecture committee.

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The 41st annual meeting of the Canadian Mental Health Association will be held June 2–4 at the Chateau Laurier in Ottawa. Dr. J. D. Griffin is general director.

* * *

Cincinnati will be the site of the annual convention of the National Association for Retarded Children. The dates are October 21–24. Registration is open and the organization invites members of all professions interested in the welfare of the mentally retarded. Further information is available from Dr. Gunnar Dybwad, executive director, 99 University Place, New York 3.

* * *

Scientists from 20 major U. S. research

centers will participate next month in a 5-session conference on research in mental retardation. It will be held May 1–3 in Philadelphia under the auspices of the Woods Schools, Langhorne, Pa., and the American Association on Mental Deficiency.

The meeting is expected to attract professional workers, research scientists, parents and educators. Cooperating will be the National Institute of Mental Health, Office of Vocational Rehabilitation, Children's Bureau, Office of Education, National Institute of Neurological Diseases and Blindness, American Psychiatric Association and Children's Hospital of Philadelphia.

Papers read during the conference will be published in the *American Journal of Mental Deficiency* and also by the Woods Schools.

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The first international medical conference on mental retardation will be held July 27–31 at the Eastland Hotel in Portland, Me. It is being organized by the Maine chapter of the American Academy of Pediatrics, the division of maternal and child health of the Maine Department of Health and Welfare, and the Pineland Hospital and Training School at Pownal.

The program will include addresses on brain anatomy, head anomalies, phenylketonuria, birth injuries, infections, mongolism, behavior disorders and psychotherapy.

APPOINTMENT

Dr. William P. Hurder has been selected to head the South's regional program in mental health training and research conducted by the Southern Regional Education Board. Announcement of his appointment as SREB's associate director for mental health was made February 16 by Dr. Robert C. Anderson, director of the board.

Dr. Hurder holds the M.D. degree as well as a Ph.D. in psychology, thus combining in his professional training two key areas in the field of mental health. Before joining SREB in 1957, he headed the State Colony and Training School in Pineville, La. From 1949 to 1954 he was assistant and associate professor of psychology and psychiatry, and psychiatric research associate at Louisiana State University.

The regional mental health program was established in 1954 by the SREB at the request of the Southern Governors' Conference and is supported by an appropriation of $8,000 from each participating state. Its purpose is to aid states and southern colleges and universities to train more qualified personnel for mental health programs and to aid in obtaining added support for needed research programs.

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Ephraim Roos Gomberg, a Pennsylvania attorney, has been appointed director of the 1960 White House Conference on Children and Youth. He will carry out the directives of the President's national committee for the conference, of which Mrs. Rollin Brown is chairman.

MEMORIAL

A committee of friends and colleagues of the late Dr. Lawson G. Lowrey has been formed and is appealing for funds for a suitable memorial. Contributions made payable to the Lawson G. Lowrey Memorial Fund may be mailed to Simon H. Tulchin, 30 E. 60th St., New York 22.

PUBLICATIONS

A revised edition of a manual titled *Volunteer Participation in Psychiatric Hospital Service* was released recently by the National Association for Mental Health.

The original manual, published in 1950, was widely used by hospital staffs and by various community groups. The revision

is written specifically for the hospital chairmen of local mental health associations. It will be particularly helpful to those near enough to state hospitals to give personal service to patients, and to associations serving the psychiatric wards of general hospitals and county homes.

The manual supplies detailed information on the necessary steps in setting up a program of services to the hospitalized mentally ill. It points out that the services—to be fully effective—must rest on a solid foundation of planned partnership between the mental health association, the hospital and the community of which they are part. It clearly differentiates between the roles of the mental health association (working through its hospital committee) and the hospital (working through its director of volunteers). It also notes the value of a community coordinating council for mental hospitals and shows how the mental health association can work with other groups in setting up a council.

Several sections of the manual are devoted to the many kinds of services that volunteers can give to the hospitalized mentally ill. There are guide lines and suggestions on recruiting, matching the volunteer to the job, training volunteers in the community and in the hospital, and introducing them to assignments and supervision. Suggested forms, examples of job descriptions, and a list of do's and don'ts are included.

A companion piece directed to mental health associations located at some distance from a mental hospital will soon be published. It will discuss the kind of services associations can provide for patients in a remote hospital.

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The most promising of modern weapons in the battle against mental illness are described in a new NAMH publication, *New Trends in the Care and Treatment of the Mentally Ill.* It was written by Leonard Engel, a topflight free-lance journalist, for wide distribution by mental health associations.

"Much that is heartening in the fight against mental illness is attributable to state and local mental health associations across the country and to the dedicated efforts of their members," says the foreword. "These people have just reason to be proud and the purpose of this pamphlet is to tell them something about the achievements that their dedication has helped to inspire and make possible."

The new pamphlet supplies a great deal of information for speeches, round-table discussions, study programs and forums. It will also be useful to libraries and to students, particularly in health, social science and psychology courses. Many other uses for the pamphlet are listed in a guide prepared by the NAMH education department.

Copies of *New Trends* are available from NAMH for 15¢ each, with special prices for quantity lots.

* * *

His own battle against mental illness is recounted by Robert E. Dahl, central regional director of the Indiana Association for Mental Health, in *Breakdown,* to be published March 30 by the Bobbs-Merrill Company.

He wrote the book, he says, because today he can see signs of hope for the mentally ill.

"There are new drugs which help calm patients and make it easier for the doctors to talk with them. In many places wards are being opened. A few state hospitals are unbarring all their windows, unlocking all their doors. Yet, despite such progress, Tag, Albert, Baker and Hiram still are confined in River's Edge. They and many

others that I knew probably will die there. This is my way of remembering them.

"And this book also is my way of remembering that far greater number—those who have been discharged by the hospital. I also write to those still to enter it. I write to all those who have shared, or who will share, experiences akin to mine—that they may know the fight is truly worth while."

Mr. Dahl, who lives in Lawrence, Ind., with his wife and two young daughters, is a graduate of the University of Missouri School of Journalism. Before joining the staff of the Indiana mental health association, he worked in the advertising department of the Indianapolis Times.

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Spanish-language editions of three popular mental health leaflets have been produced by NAMH for distribution through church organizations, social and fraternal groups and health departments. The leaflets are *What Every Child Needs for Good Mental Health, Some Things You Should Know about Mental and Emotional Illness* and *Mental Health Is 1–2–3.*

Mental health associations in Spanish-speaking areas have long reported a need for the leaflets, which easily and quickly familiarize readers with basic mental health ideas.

The translations, prepared for NAMH by the Puerto Rican Department of Health's mental hygiene bureau, have been approved by Spanish-speaking Americans of Mexican and Cuban backgrounds.

Quantities of each are available from NAMH at the following prices: 100–999, $1.90 per 100; 1,000–9,999, $1.80 per 100, with still lower prices for larger quantities.

NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Voluntary Promotional Agency of the Mental Hygiene Movement founded by Clifford W. Beers

OBJECTIVES: The National Association for Mental Health is a coordinated citizens organization working toward the improved care and treatment of the mentally ill and handicapped; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illnesses and handicaps; and for the promotion of mental health.
